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Evaluation of the GRMA/PRIME Self-Directed Learning, Client Provider Interaction and Adolescent Reproductive Health Initiative

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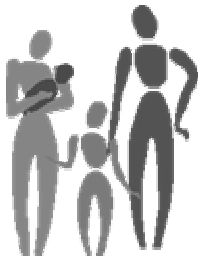
By: Constance Newman, MSW, MPH
Maia Ambegagokar, MBA, MSc
Mercy Abbey, MSc
Alexandre Muhawenimana, MD
Perle Combary, PhD

PRIME II



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Intrah
School of Medicine
The University of North Carolina at Chapel Hill
CB # 8100, 1700 Airport Road, Suite 300, Chapel Hill, NC 27599-8100 USA
Phone: 919-966-5636 ●Fax: 919-966-6816
E-mail: intrah@intrah.org http://www.intrah.org

East/Southern Africa
P.O. Box 44958
00100-Nairobi
Kenya
Phone: 254-2-211820
Fax: 254-2-226824

Asia/Near East
IFPS Liaison Office
50M Shantipath
Gate Number 3 Niti Marg
Chanakyapuri
New Delhi 110021, India
Phone: 91-11-464-8891
Fax: 91-11-464-8892

West/Central/North Africa
B.P. 5328
Dakar-Fann, Sénégal
Phone: 221-864-0548
Fax: 221-864-0548

Latin America/Caribbean
Federico Henríquez y Carvajal #11
Los Casicasaz
Santo Domingo, Dominican Republic
Phone: 809-686-0861
Fax: 809-221-2914

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Authors

Constance Newman is the Senior Evaluation Manager for PRIME's headquarters in Chapel Hill, North Carolina.

Maia Ambegagokar is a Demographer based at the London School of Hygiene and Tropical Medicine, England.

Mercy Abbey is a Social Scientist based at the Health Research Unit of the Ministry of Health, Accra, Ghana.

Alexandre Muhawenimana is the Regional Program Officer for West, Central and North Africa, and is Resident Advisor/Team Leader in the Ghana country office.

Perle Combary is PRIME's Regional Program Evaluation Manager for the West, Central and North Africa office based in Dakar, Senegal.

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  - Grace K. Anyadi
  - Comfort O. Ennimful
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Acronyms

ARH	Adolescent Reproductive Heath
CPI	Client-Provider Interaction
EC	Emergency Contraception
FP	Family Planning
GRMA	Ghana Registered Midwives Association
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IEC	Information, Education and Communication
MOH	Ministry of Health
PAC	Postabortion Care
RH	Reproductive Health
SDL	Self-Directed Learning
STIs	Sexually-transmitted Infections

Executive Summary

In December 1999, PRIME designed and implemented a follow up and evaluation of the Ghana Registered Midwives Association's Adolescent Reproductive Health/Client Provider Interaction (CPI) Self-Directed Learning initiative, a pilot program for 59 midwives which took place between March and July 1999 in three regions of Ghana. The pilot program consisted of a 5-month course combining multiple learning approaches for knowledge and skill acquisition, including print modules (with practical exercises and self-assessments); paired learning; facilitator visits; and group peer review.

The project goal was to demonstrate that self-directed learning could improve the quality of and access to RH/FP services for adolescents by improving midwives' CPI skills. The follow-up evaluation addressed the following questions: Can self-directed learning (SDL) improve client-provider interaction? Can SDL help providers develop and expand services for adolescents? And, how can we improve the implementation of SDL interventions? There were two dimensions of evaluation: implementation and results evaluation. Implementation evaluation assessed activities and processes, factors related to program success or failure; and the extent to which the intervention was implemented as planned. The program was largely implemented as planned, but faced transportation, communication and time management challenges (though the first two were not unexpected due to the distances and communications infrastructure of Ghana).

Results evaluation focused on how well the SDL initiative met its objectives, such as improved knowledge, increased skills or on-the-job application of learning. The design of the results evaluation consisted of a comparison of pre- and post-intervention indicators related to knowledge, opinions and practice of the learners group in the area of Adolescent Reproductive Health; and a comparison of a group of 30 learners with a group of 30 non-learners on counseling/client provider interaction skills. There were significant differences between the learner and non-learner groups along the following dimensions: comfort and confidentiality offered to clients during counseling; use of materials such as models, samples and flipcharts when explaining medical information to clients; discussion of sexuality with adolescent clients; explanation of contraceptive usefulness to young clients; and discussion of STIs/HIV/AIDS. The study concluded that the SDL program learners performed better on critical CPI skills and offered improved or more specialized services for adolescents than those who had not participated. Due to the limited scope of the midwives record-keeping related to adolescent services, and the short period between the end of the program and the follow up, it was not possible to evaluate service-level results such as increase in numbers of adolescent clients.

Other project achievements reported by learners and GRMA staff included the following: 97% of GRMA midwives completed the 5-month program; many

midwives altered the physical environments of their services to enhance privacy for young clients; an increased sense of professional collaboration and interest in reading and learning among participating GRMA midwives; and improved interactions with adolescents.

Lessons learned include: SDL is an effective learning approach for improving the performance of RH/FP service providers, and the learner support system is critical to that success; Facilitators must be well prepared and compensated for their participation; SDL materials should be thorough, practical and engaging, with very clear directions for learners; and, curriculum development skills need to be transferred to host country partners so that they may be adapted to other health areas in the future.

Introduction

Background and Problem Statement

In 1999 the Ghana Registered Midwives Association (GRMA) and PRIME implemented the pilot phase of a project entitled "An Innovative Learning Approach to Improving Client-Provider Interaction and Family Planning/ Reproductive Health Service Quality and Access in Ghana." The learning program focused in particular on the provision of adolescent reproductive health (ARH) services and the improvement of client-provider interaction (CPI). The participants (referred to as learners) were active members of the GRMA who run their own maternity homes as private-sector reproductive health care businesses. The project's innovative approach consisted of a program of self-directed learning (SDL), combined with an extensive learner support system, for midwives who had been out of school for several years and for whom off-site training was disruptive to the running of their clinics. The project was designed and developed during 1998 and 1999 and was implemented in the Ashanti, Brong Ahafo and Eastern Regions of Ghana from March 1999 to the first week of August 1999. This report describes and presents the results of the evaluation and learner follow-up conducted at the end of the pilot phase in September-November 1999.

The rationale for the GRMA SDL/CPI/ARH initiative had two sources:

First, findings from previous assessments in Ghana, most notably the 1997 PRIME/GRMA/Focus "Assessment of GRMA´s Private Sector Reproductive Health Service Providers," highlighted areas where service quality improvements were appropriate. These areas included: updated FP/RH knowledge; improved counseling and client-provider interaction (CPI) skills; improved familiarity with national policies, standards and protocols; and new strategies for applying these policies to service delivery, in order to increase service access for adolescents.

Second, while GRMA was committed to providing in-service training to its membership, its leadership is mindful of the fact that in-service training should not take midwives away from their service sites for extended periods of time (i.e., more than three days), because as private-sector providers the midwives lose income and disappoint their clients when absent for long.

Self-directed learning was considered a potential in-service training alternative for GRMA for several reasons. First and most importantly, SDL is an approach that offers providers a way to improve knowledge and skills without incurring a long absence from service. Second, in that SDL allows self-pacing within established time limits, learners are able to progress at their own speed and to balance learning activities with the demands of work and home. Third, it permits reproductive health service providers the opportunity of immediately applying what they are learning to their work settings, potentially making the training more directly

relevant and practical than class-room learning. For these reasons, the benefits of SDL seemed to respond to the GRMA midwives in-service training needs. Together, PRIME and GRMA decided to pilot the SDL/CPI/ARH initiative.

A central question for the SDL/CPI initiative was *Can SDL have an effect on CPI skills (i.e., can CPI be improved through self-directed learning)*? In other words, while SDL could reasonably be expected to improve knowledge at least as well as conventional training, could the SDL approach, incorporating as it does a range of practical activities and peer support mechanisms over a period of time, positively affect the application of new skills in the workplace? Another key question was *Can SDL help providers to develop and expand services for a new client group, adolescents, and thereby increase adolescents' access to reproductive health care services?* In addition, there was a basic practical question: *Given the complexity of the SDL initiative's learner support system (as compared to traditional one-time, single location training), could the implementation of the initiative be managed feasibly?* These are the key research problems addressed by the study described in this report.

This evaluation report first provides an overview of the SDL initiative, its objectives, main activities, key design components and purposes of the evaluation. The report then turns to the evaluation methodology, describing data collection and analysis techniques. Results are then presented in two parts, first those having to do with effects of the initiative on SDL-trained midwives knowledge, opinions, skills, range of services provided and adolescent clients views. Secondly, results related to the implementation of the initiative are presented. Finally, recommendations are presented.

Description of the SDL/CPI/ARH Initiative

Summary

Fifty-nine midwives, from three regions of Ghana, participated as learners in this first phase of the SDL initiative between March and August of 1999. They were supported by six facilitators, also midwives, whose role was to encourage the learners and help them to practice their new skills through role-plays and to implement adolescent-focused service delivery changes in accordance with their new knowledge. The design of this self-directed learning initiative involved self-study by the midwives of six ARH modules (produced as spiral-bound booklets), practical exercises and self-assessment undertaken while studying the modules, peer support and mutual encouragement in the form of joint practical sessions by two learners paired together, and facilitation by midwives whose role was to guide and assist the learners by visiting them and holding monthly meetings in each of the three regions.

The following section of the report presents the objectives, schedule, content, process and participants in greater detail.

SDL/CPI Initiative Objectives

The broad objectives of the PRIME/GRMA SDL/CPI initiative, as described in the project document were to:

1. Improve the range/availability of integrated reproductive services;
2. Demonstrate effectiveness/effects of SDL approach on CPI of primary providers; and
3. Improve FP/RH knowledge, counseling skills, and the effective application of service policies.

Course Objectives

The following objectives were formulated more specifically for the GRMA SDL/CPI course of study:

1. Master the process of self-directed learning;
2. Apply the principles of good counseling to practice; and
3. Apply the principles of client-provider interaction to reproductive health care of adolescents.

SDL/CPI Course Schedule and Modules Content

SDL/CPI course objectives were to be met through a six-module course of self-directed learning. The implementation of the project took place during 1999, as follows:

Jan - Feb	Stakeholders meeting, drafting of modules, development of work plan
Mar	Pre-testing of modules, orientation of facilitators and learners
Apr - Aug	Implementation
Sept - Nov	Evaluation

The content of the six modules covered counseling, IEC and reproductive health service provision for adolescents, as follows:

Module 1: Introduction to the SDL Programme

Introduces the objectives of the SDL/CPI Initiative

Explains client-provider interaction and self-directed learning

Describes how to schedule activities and studying time

Describes how to work with a paired learner

Module 2: Counseling Adolescents

Discusses effective counselling and the steps involved in counselling

Describes how counselling adolescents is different from counselling adults and addresses special challenges when counselling young clients

Module 3: Adolescent Reproductive Health

Describes what adolescence is and how to provide RH services to adolescents

Module 4: Information, Education and Communication for Adolescents

Describes how to organise and conduct IEC activities on ARH in the community

Helps with identifying topics for IEC sessions

Module 5: Providing Reproductive Health, Family Planning, Emergency Contraception and Postabortion Care Services to Adolescents

Explains how to describe reproductive systems to adolescents

Indicates how to provide family planning to adolescents

Explains emergency contraception and how to provide it

Explains postabortion care

Module 6: Providing STI/HIV/AIDS Services to Adolescents

Explains how to recognise, treat and manage STIs among adolescent clients

Explains HIV and AIDS and how to help adolescents avoid infection

Modules 1 and 2 were given to learners and facilitators at an orientation in March 1999. Learners at their work sites completed Module 2 by the end of April 1999. Modules 3 and 4 were given to learners together in April because they were related, and were completed at work sites by the end of May 1999. Module 5 was given to learners in May and was completed by the end of June 1999. Module 6 was given to learners in June and was completed by the end of July, 1999, except for Ashanti region, whose last peer review meeting was scheduled to coincide with their monthly meeting, scheduled for the first week of August 1999.

A. SDL/CPI Initiative Design Components

The design of the SDL/CPI course included the following six components, designed to increase the likelihood that the independent learners would acquire new skills and be able to put them into practice:

1. **Self-assessment**:
   Assessment exercises, which occurred at the beginning and the end of each module, gave the learners a chance to see how much they knew before and after the lesson. These exercises were designed for the benefit of the learners and were not objective tests to demonstrate mastery of module objectives.

   Self-study:
   Promoted an active relationship between the learner and the content without direct supervision.

   Self-pacing permitted the learner to decide when and for how long to study. Application exercises asked the learner to apply it now. Activity planning exercises, which encouraged learners to put new skills to work by improving

some aspect of adolescent service access or quality, were designed to move learners beyond passive learning of information to active implementation of changes in service delivery.

Paired learning:
Permitted two learners to cooperate in processing new information, practicing new skills and engaging in joint problem-solving.

There was to be one paired learning meeting per module. For these meetings one midwife in the pair traveled to the other's site to meet. Learners were expected to practice skills through discussion and role-play, providing feedback to each other and helping each other to understand and apply their knowledge.

2. **Facilitation**: Visits by facilitators

   The facilitators' role was to review and clarify new information with learners, offer help in problem solving and model new skills and behaviors by conducting and observing role-plays. Facilitators were to visit learners once a month, travelling from their own clinics to meet at the maternity of a learner.

3. **Peer review**: Two-hour sessions once a month bringing together all learners in a region

   Scheduled before the regular monthly business meeting of the GRMA region, the peer review sessions gave learners in each region the opportunity to: meet with other learners and practice new skills; receive feedback from other learners and facilitators; share activity plans; find ways to apply skills to the job; schedule the next paired learner and facilitator visits; and receive a copy of the next module.

   Paired learning, facilitation and peer review were parts of the "learner support system" to decrease isolation and promote active learning and application of new knowledge.

B. SDL/CPI Participants

The learners in this course were fifty-nine GRMA member midwives from the Brong Ahafo, Eastern and Ashanti Regions who run their own private-sector clinics. They were invited to participate in the course after being identified by GRMA′s central office as active members. Active GRMA members were defined by the following criteria and identified by GRMA's central office staff: midwife members who paid monthly dues, who attended the monthly business meeting on a regular basis, and who sent in required reports. Two regions had 30 participants in this program and one had 29 participants.

In addition to the learners, the SDL initiative involved six facilitators, two per region, also selected by the central office. These were also GRMA member midwives running private sector maternity homes. They had skills in training or facilitation and were felt to be the sort of people who could provide support to

their peers. Each facilitator had about 10 learners to support, visiting them at their maternity home once a month. The facilitators also organized and led the monthly peer review meetings.

The GRMA central office in Accra coordinated the initiative. In addition to the usual support from the Executive Director and her program, financial and administrative staff, the office identified a Coordinator for the SDL initiative. The Coordinator served as the focal point for any issues arising in the implementation of the initiative.

C. *Evaluation Purpose and Objectives*

The evaluation of the SDL/CPI initiative took place in October and November 1999. The overall purpose was:

To assess the implementation and results of the GRMA/PRIME SDL/CPI initiative, the specific objectives were to:

1. Assess the achievements and results of the PRIME/GRMA project and the SDL program objectives
    a. Assess changes in SDL-trained midwives self-reported RH service practice from baseline, and compare with non-SDL trained midwives (post-training);
    b. Assess changes in SDL-trained midwives opinions and knowledge regarding selected ARH (FP/PAC/STI) services for adolescents from baseline, and compare with non-SDL trained midwives;
    c. Compare CPI/counseling skills of SDL-trained and non-trained midwives;
    d. Assess changes since baseline in the type and number of reported ARH services provided in sites with SDL-trained midwives;
    e. Assess post-training changes in ARH service use in sites with SDL-trained midwives;
    f. Describe adolescent clients' perceptions of ARH services offered by SDL-trained midwives;
    g. Compare adolescent clients' perceptions of CPI in sites with SDL-trained and non-trained midwives;
2. Assess the extent to which the SDL course was implemented as designed/planned;
    a. Describe the activities and achievements of the SDL initiative;
    b. Assess the adequacy and effectiveness of the SDL learner support system;
    c. Evaluate the quality, availability and use of SDL modules, the facilitator guides and related materials for learners and facilitators;
    d. Identify any facilitating/hindering factors related to design, implementation and evaluation phases of the SDL program; and
3. Identify lessons learned and recommendations regarding the design, implementation and evaluation of the SDL program.

Methodology

Evaluation design

The evaluation design was intended to address the three main objectives cited above: 1) assess the achievements and results of the PRIME/GRMA project and the SDL program objectives; 2) assess the extent to which the SDL course was implemented as designed/planned; and 3) identify lessons learned and recommendations regarding the design, implementation and evaluation of the SDL program. To assess these objectives, a combination of methods from both implementation and results evaluation were employed (see Chart 1).

Chart 1: Implementation and results evaluation

IMPLEMENTATION EVALUATION *(Provides documentation of project activities)*	**RESULTS EVALUATION** *(Measures the outcomes or achievements of a program, e.g., post-intervention differences in knowledge, skills, service delivery or other changes)*
Purposes • Documents the nature of the intervention or important parts of it (e.g., activities and processes) • Provides a glimpse into the reasons for the success or failure of an intervention, or an explanation for an intervention's results (or lack thereof) • Describes how the intervention was supposed to work and *how/if* it actually worked or took place as planned	**Purposes** • Assesses whether the project met its objectives, such as – Improved knowledge – Increased skill levels – On-the job applications – Service-level results

Methods/Instruments	*Methods/Instruments*
• Self-administered questionnaires • In-depth interview questionnaires • Focus group discussion guides	• Written pre/post test of knowledge ("Knows about") • Checklist to observe skills ("Can do") • Form to assess behavior or application of learning ("Does do") • Document review forms or client interviews (implications for service delivery)

The use of both types of evaluation approaches and methods is important to document not only the effects of the intervention or program but also the mechanisms by which these effects were produced. When the information is considered together, evaluators and project staff are able to identify what specific activities were undertaken, how well these activities were implemented and received and what changes, if any, these activities produced. The resulting data allow for a much richer understanding and appreciation of a project's history, results and wider applicability than when either evaluation method is utilized by itself.

For the evaluation of the SDL project, results at the level of SDL program participants were assessed by comparing data related to the knowledge, skills, and self-reported practice, and clients perceptions of practice, for a sample of learners with that of either the learner group at baseline or with a control group of learners. The implementation process was assessed by interviewing learners, facilitators and GRMA staff during a post-intervention follow-up and by reviewing various data collection forms, including those completed by learners after each module.

The results evaluation design was not intended to answer broader questions that go beyond this specific course. For example, it was not intended as part of this evaluation to compare the SDL approach to other training approaches for improving skills and performance. To demonstrate the foregoing would have required an experimental or quasi-experimental research design in which participants or regions were randomly assigned in advance to different types of training. The evaluation design, combining as it does observation of skills practice, self-administered questionnaires, testing of knowledge and interviews with key informants was considered by the evaluation team to be sufficiently robust for the purpose of examining the implementation and results of this particular course. The discussion in subsequent sections will indicate that there were some weaknesses in the methodology, but as the overall results will show, the evaluation design used did serve to identify how the SDL course had been successful and in what ways it might be improved.

Evaluation results

The purpose of the evaluation of results was to assess changes, if any, in learners' knowledge, skills and services offered. The term "results" is used, rather than "effects" or "impacts" because, as stated earlier, measurement of those outcomes would require the use of an experimental or a quasi-experimental research design. In either case, identification of control subjects before the start of the intervention and collection of baseline information from both the control and the intervention subjects would be necessary to attribute changes with confidence to the intervention. In this evaluation, some baseline information was collected from the participants in the SDL course, but controls were not selected until the time of the follow-up evaluation.

The evaluation design is diagrammed as follows:

	3/99	3 - 7/99	10/99
I-GROUP Midwives who participated in the SDL/CPI course	O_1	X_1	O_2
C-GROUP Midwives who did not participate in the SDL/CPI course			O_3

Where X_1 = Administration and evaluation of the implementation of the 5-month six module SDL/CPI course

Where O_1 = Baseline measures of knowledge, opinions and self-reported practice

Where O_2 and O_3 = Post-intervention measures of knowledge, opinions, self-reported practice, observed CPI/counseling skills

Sampling plan

The population of midwives from which both samples were drawn consisted of "active members," i.e., midwives who attended monthly meetings on a regular basis, who sent in monthly reports and who paid association dues. The intervention group (I-group), referred to as "learners," had 30 midwives selected randomly from a population of 59 midwives who had participated in the SDL/CPI course in the Eastern, Ashanti and Brong Ahafo regions. The non-intervention group (C-group), referred to as non-learners," had 30 midwives selected randomly from a population of 54 midwives from the Central, Volta, Greater Accra and Western regions. GRMA's Executive Director made the selection of both learner and non-learner populations using GRMA records.

In order to minimize the possibility of contamination, the C-group of "non-learner" midwives were selected from regions in which it would have been unlikely that they would come in contact with learners at monthly meetings. This ruled out selection of the C-group from the I-regions of Ashanti, Brong Ahafo and Eastern regions.

The remaining regions from which to draw samples were:

- In the extreme north, too far to drive for a random sample, and excluded on this basis; and
- the southern regions, closer to Accra, where it was thought that increased contact with GRMA-central might keep midwives abreast of new trends in midwifery practice, and hence, might render their skills tests scores more similar to I group scores than might otherwise have been the case. While this constitutes a limitation of the evaluation, the C-group was nevertheless selected randomly from these regions because their relative proximity might allow the evaluation team to reach 30 midwives in the time available.

Both the I-group and C-group samples were stratified proportionally to urban and rural service setting (See Table 1 below). Stratification seemed advisable in the I-group because it was believed that urban or rural service site setting might have an influence on certain response variables, i.e., learners' perceptions of the program and adolescent service use as reflected in service records. While these two response variables were not assessed in the C-group, it was thought that stratification would add precision to the data from the C-group.

Table 1: Percentage of midwives by type of site in the study sample

Group	I-group (N=30) %	C-group (N=30) %
Rural	81.4	61.1
Urban	18.6	38.9
TOTAL	100.0	100.0

Sample achieved

Learner sample (I-Group)

In order to obtain the final sample of 30 participants in the SDL initiative, a total of 43 individuals were randomly selected in three stages, from the SDL course population of 59. The third sampling stage turned out to be necessary because a large proportion of the original sample and the alternate sample had been missed because they were not at the site when the research team arrived. Overall, the missed group is 13 out of 43 to obtain 30 (see Appendix 1).

Control sample (C-Group)

In order to obtain the sample of non-participants to serve as a control group, an artificial population had first to be created. This was accomplished by asking the GRMA Executive Director and the SDL Coordinator to select a group of midwives (from regions that had not participated in the SDL initiative) according to the same criteria that had been used to select the SDL participants. The criteria used were that the midwives be active members of GRMA, who pay their dues and attend regional meetings regularly. In this way, a sampling frame of 54 was created. In order to obtain the final sample of 30, a total of 37 were randomly drawn in two phases. The missed cases were seven out of 54 to obtain 30 (see Appendix 2).

Comparability of the samples

Although the sample was selected at random from a population comparable along several important dimensions, the I-group and C-group samples were not compared on the basis of age or other factors that may have influenced the results of the analyses. As a result, the samples were not completely comparable. In addition, there was a fairly high rate of missing subjects, which required multiple sampling

stages. However, neither of these shortcomings appears likely to bias the results of the study in a particular direction.

Evaluation of implementation

The implementation of the SDL course was assessed primarily by use of in-depth interviews in accordance with interview guides developed by the evaluation team. Three semi-structured in-depth interviews of key informants other than the learners were undertaken as part of the evaluation methodology. Two of these were individual interviews, one with the GRMA Executive Director and one with GRMA's Coordinator of the SDL/CPI initiative. The other interview was a group interview with the six facilitators of the SDL, which was conducted using a guide similar to a focus group guide. These facilitators were the key implementers of the SDL initiative and thus the purpose of the interviews was to obtain their opinions about the process and recommendations for improvement.

Learners were also a key source of information about the implementation process. In-depth interviews were conducted during the fieldwork with a sample of thirty learners to understand their views about the quality, availability and use of materials and the adequacy, relevance and applicability of the course, and, especially, the effectiveness of the SDL learner support system.

In addition, the evaluation team reviewed forms completed during the SDL course by learners. These forms, filled in by learners after each module, provide insight into how well the course proceeded and what obstacles the learners faced.

To complement these main sources of information and to assess the design phase of the evaluation, a questionnaire specifically about the process of planning and designing the course was completed by some of the SDL program designers.

Data Collection Techniques and Instruments

There were eight instruments developed to collect data on implementation and achievements from various data sources in Ghana, Chapel Hill and Dakar. Existing data were also reviewed. The following list is a description of data collection tools and techniques (see Appendix 3).

ARH Opinions, Practice and Knowledge Questionnaire: The purpose of this instrument was to assess various dimensions of performance through written responses by midwives in both the I- and C-groups (Appendix 4).

Tool to Observe CPI/Counseling for Adolescent Reproductive Health: The purpose of this instrument was to assess critical skills in CPI/counseling performance of I- and C-group midwives, using a checklist filled out by trained observers from the Ministry of Health (MOH) (Appendix 5).

Learner Interview Guide: The purpose of this instruments was to assess SDL/CPI learners (I-group) perceptions about various dimensions of the course, including the learner support system, the quality, availability and use of materials,

and factors hindering or facilitating participation in the program. Trained interviewers from the MOH conducted the interview (Appendix 6).

Adolescent Client Interview Guide: The purpose of this instrument was to assess perceptions of adolescent clients served by both I- and C-group midwives, with attention to services received and how the client felt he/she had been treated. Trained interviewers from the MOH conducted the interview (Appendix 7).

Service Statistics Form: The purpose of this instrument was to record data found in the records of the I-group midwives, in order to compare the number of adolescent clients, counseling and IEC activities before and after completing the SDL/CPI course. The form was filled out for 1998 and 1999 by one of the trained observers, with the help of a maternity home assistant (Appendix 8).

The GRMA Executive Director In-depth Individual Interview Guide, The SDL Coordinator In-depth Individual Interview Guide, and the Facilitators In-depth Group Interview Guide: Three in-depth interviews of key informants were undertaken as part of the evaluation methodology. Two of these were individual interviews, one with the GRMA Executive Director and one with GRMA's Coordinator of the SDL/CPI initiative, and the other consisted of a group interview with the six facilitators of the SDL. These individuals were the key implementers of the SDL initiative and thus the purpose of the interviews was to obtain their opinions and recommendations. Each interview guide elicited information about slightly different areas, but taken together they provided information on:

- the planning and development of the initiative, including development of the initial ideas and action plans, adequacy of the time and resources available, and usefulness of the various inputs;
- the modules and supporting materials, including the presentation and content of the materials and their timely availability;
- the implementation of the initiative, including the responsibilities of the various actors, the functioning of the learner support system and the major problems encountered;
- the monitoring process, including interactions between the office and the field and the usefulness of the various reporting forms used;
- the capacity developed by the initiative within GRMA, including what might be needed to make it sustainable; and
- the overall assessment of the initiative, including how well it met GRMA's objectives and expectations, what lessons have been learned by GRMA, what recommendations GRMA would make for improving the program, and what thoughts or proposals GRMA has for next steps.

The evaluation included other sources for some of this information, including the learners' interviews and the questionnaire for the program designers (Appendix 9).

GRMA/PRIME Self-Administered Questionnaire on the SDL/CPI Design/Development Phase: This instrument assessed the perceptions of persons who were involved in the design/development phase of the SDL/CPI initiative, in order to formulate recommendations for improved SDL design/development processes. This instrument was a self-administered questionnaire with handwritten responses from two GRMA staff, and electronic responses and transmission to the evaluation team in Accra by the two PRIME staff and one consultant in Chapel Hill and Dakar (Appendix 10).

Existing Data

Several tools were developed as a part of the SDL/CPI course monitoring system. The evaluation team used these tools [the Module Evaluation Form; the Learner Accomplishments Form; the Peer Review Report Form; and the Field Visit Checklist (Appendix 11)] to assess various aspects of program implementation.

Data Collection Strategy and Schedule

Evaluation of Achievements

Thirteen MOH public health nurses/midwives were trained in observation and interviewing skills from October 5-9, 1999. Because five days was a short period of time for training data collectors in interviewing or observation, there were two training sessions held simultaneously. Participants were put into observer or interviewer groups based on the results of a self-assessment form with questions about participant's previous training, experience and comfort level in relation to interviewing and observing.

The instruments used during for the field follow-up by the 13 data collectors included:

- Learner Interview Guide
- Tool to Observe CPI/Counseling for Adolescent Reproductive Health
- Service Statistics Form
- ARH Opinions, Practice and Knowledge Questionnaire
- Adolescent Client Interview Guide

Participants were put into four teams of three (with one extra). Instruments 1, 2, 3 and 5 were field-tested over two and a half days in simulated and clinic settings and the instruments were revised.

Data collection in the I- and C-regions occurred from October 12-25. The strategy was to send all four teams simultaneously to the three I-regions in Week 1, meet with them at the end of the first week to review issues and retrieve data; and then let them cover the four C-regions in Week 2. Data retrieved at the end of the first week were processed during the week of October 18-22. Data from the C-regions were processed from October 26-29.

Adolescents clients were contacted for interviews by the midwives. Their informed consent was obtained by the interviewer before the interview. Individual identifiers such as names and addresses were not collected and every effort was taken to ensure that their responses were confidential. It is likely that this method of selection introduced a positive bias into their comments, as adolescents were selected by the midwives and not all adolescents presented for interviews. One can assume that only adolescents who would provide favorable views of the midwives were invited to be interviewed. This selection bias, however, should have affected both learner and C-group responses equally.

Evaluation of Implementation

As mentioned above, there was considerable existing data from the SDL/CPI course at GRMA in Accra. These data were entered into the computer from October 6-14 and analyzed by the PRIME team during October. The in-depth interviews and the questionnaire on the SDL/CPI Design/Development Phase were applied between October 15 and October 31. These activities occurred

simultaneously with a field follow-up to assess certain aspects of implementation as well as achievements.

Results

This section presents the findings of the evaluation in two parts. First, we present the achievements of the SDL/CPI initiative at the level of the learners' counseling skills, range of adolescent reproductive health services offered, knowledge and opinions. As described above, this information comes from comparing the sample of SDL learners (known as the follow-up group) to themselves before the start of the initiative (known as the baseline) and to a sample of non-participants (known as the control group). We then present the findings from the review of the implementation process, beginning with the views of the learners and other implementers regarding self-directed learning.

The findings are extremely positive. The SDL participant midwives demonstrated better skills when counseling an adolescent in a role-play situation. The number of participant midwives offering adolescent reproductive health services increased and their knowledge of policies regarding adolescents improved. In addition, the learners and the implementers were enthusiastic about the SDL approach to training. Some adjustments need to be made to overcome small problems with the implementation process and to improve future evaluation approaches, but overall the results show the 1999 pilot phase of the GRMA/PRIME SDL/CPI ARH initiative to have been a success.

Assessing the Achievements of the SDL/CPI Initiative at the Level of the GRMA Learners

Observation of Counseling Sessions with Adolescent Clients

Observation tool and methodology used

One of the objectives of the evaluation was to compare the counseling skills and the client-provider interaction of a sample of SDL-trained midwives and a sample of midwives who did not participate in the SDL initiative. This was accomplished by having a trained observer (who was also a midwife herself) watch a counseling session and indicate on an observation checklist whether she did or did not observe certain behaviors or actions on the part of the midwife. The instrument contained five sections, each one emphasizing different key areas of the counseling process, as follows:

1. Establishing rapport and maintaining a good connection;
2. Gathering information and listening;
3. Providing information and explaining;
4. Decision-making and problem-solving;
5. Planning next steps.

(See example of the observation tool in Appendix 5.) The items on the observation checklist are the same as those on the counseling task checklists in the SDL course modules used by the learners.

The observed counseling session was conducted using a role-play, with one of the enumerators playing the role of an adolescent. This approach was adopted in order to overcome three common problems with quality of care observation methodologies. First, it is often very difficult for a team of researchers to find the exact type of client they desire to observe at the clinic when they arrive. This difficulty can lead to very small sample sizes. Secondly, real clients may vary greatly in their need for information or encouragement, leading to inconsistency in the type of counseling observed by enumerators. Thirdly, observation of real clients requires careful attention to issues of confidentiality, and even when great care is taken, adolescent clients in particular may be especially unlikely to behave as they would if there were no outsider present. For all these reasons, a role-play was deemed the most effective way of gathering consistent and reliable information about the counseling skills of the two groups of midwives.

Critique of the Methodology

The instrument was applied to the sample of 30 learners and to another sample of 30 non-learners. As discussed in the methodology section, a deliberate effort was made to ensure that the control group was as similar to the learners group as possible by using the same selection process and criteria.

Despite this, there are two aspects of the methodology that may have biased these counseling results towards the positive (that is, making the learners' results appear even more successful). First, the replacement of sampled individuals during the fieldwork may have led to a final sample group of more highly motivated individuals. This is because the research teams were requested (in order to save time and money) not to return for a sampled individual if she was away for a few days. Instead, they were to select an alternate from a list of alternates sampled in the same way as the initial cases. This ended up occurring more often than predicted, so that six sampled individuals were dropped from the sample because of absence from site. In order to replace these, all the ten sampled alternates were visited, but only five were found at site. Three additional alternates were selected from the remaining population while the teams were in the field, and the remaining one case was chosen for convenience of location from those three by the enumerators in the field. Given that there was a total population from which to select the sample of only 59 individuals, the missed and not-contacted group of 13 is a large subset. This group may have represented people who travel often away from site and who may have been less likely to complete the SDL/CPI modules in total. On the other hand, as discussed in the methodology section, a very similar process was followed in obtaining the control cases, with seven sampled individuals from a population of 54 missed and replaced from two samples of alternates in

order to obtain the total of 30. One could therefore reasonably argue that the same bias is to be found in the control cases as in the learners.

Secondly, and more importantly, the research teams conducting the observations were not blind to the status of the sampled cases. They knew which cases were trained and were therefore expected to conduct better counseling sessions. Informal comments from the teams indicated that they went looking for differences in the attitudes and behaviors of the trained midwives and that they found such differences. This may represent a more serious bias in the results. In general, it is preferable that the observers be completely unaware of which individuals have and have not received the intervention under study.

A further issue raised by several commentators on these results is in the use of a role-play to observe workplace performance. As part of the SDL/CPI course, the learners practiced applying their skills with the use of role-plays during the paired meetings and the peer review meetings. It is possible therefore that the researchers were really observing the skills that the trained midwives had developed in play-acting counseling sessions with other midwives. It is very difficult to design a methodology to overcome this problem, as discussed above, because real clients are not always present and may not wish their privacy to be compromised by the presence of an outsider. One possible approach to reducing this bias might be to engage actual adolescents to serve on the research team in the role of clients, thus creating a more realistic situation for the observers. The use of (carefully trained) adolescent mystery clients is also a possibility, assuming of course that the membership of the organization to be studied in this way has given its consent early on in the project to the use of that methodology.

Despite these concerns, the analysis of the results indicate, as demonstrated below, that the SDL/CPI trained midwives performed better when counseling an adolescent in a role-play than the non-SDL/CPI midwives.

Scoring the Overall Results

The mean scores earned by both the learners and the non-learners can be compared for each section of the observation tool and for the results as a whole. This was done by calculating the average number of points earned by the learners and the non-learners for each section. In scoring the results, two different weights were given to the actions appearing on the observation checklist. Some of the actions were deemed by the evaluation team to be "critical skills." Skills defined as "critical" are those that are essential to the safe and effective provision of services. As a result, these critical skills were given a higher weight of "2." (Critical skills are noted with an asterisk on the observation tool.) All other counseling actions counted for a weight of "1." Thus, each tick for "yes" shown on the observation tool was worth either one or two points.

Comparing the Mean Scores of the Learner Group and the Non-learner Group

Using the scoring system outlined above, mean scores were calculated for each group. The results are presented in Table 2 below. Due to the small sample sizes, a non-parametric test, the Kruskal-Wallis H, was used to test the significance of the difference in the means. However, the results are consistent with those obtained when testing the difference in the means using the ANOVA test, which assumes a normal distribution.

The results show that the mean scores for the sample of SDL/CPI trained midwives are higher than those for the non-learner group, and that the difference between the means is statistically significant for all but one section of the observation tool. The mean overall score is also higher for the learner group, and this difference is also significant. Thus, overall the SDL participants scored significantly better than the non-participants did when observed in a role-play counseling an adolescent. It is appropriate to keep in mind the methodological concerns cited above when interpreting these results. However, it does appear that the SDL trained midwives exhibit better skills at counseling adolescents about reproductive health than those who have not had the training.

Table 2: Comparison of mean scores on selected counseling tasks

Section of observation instrument	Skills measured	Highest possible score	Learners' mean score (N=30)	C-group mean score (N=30)
1 - Establishing rapport and maintaining a good connection	Greeting, confidentiality and privacy, caring manner, attentiveness	9	8.73	7.07**
2 - Gathering information and listening	Use of open ended questions, listening to answer, asking about feelings, asking about STI/HIV risks	7	4.17	3.67
3 - Providing information and explaining	Encouraging client to talk, use of visual images, models, or samples, linking technical information to clients situation, giving accurate information concisely, explaining issues related to adolescents	14	9.43	6.33**
4 - Decision-making and problem-solving	Helping client identify decision areas, helping client examine consequences, summarizing discussion, allowing client to make decision without offering premature solutions	9	6.57	5.1*
5 - Planning next steps	Confirm decision and check understanding, refer to other resources/ support, thank client.	6	4.57	2.23**
Overall observation score	**TOTAL**	45	33.47	24.4**

* Difference is significant at $p < .05$

** Difference is significant at $p < .01$

Comparing Results on Critical Skills

In addition to the overall results, we compared the two groups' results on the "critical skills" identified as such by the doctors and midwives on the evaluation team. These results were compared item by item using a two-by-two table for each

item and measuring significance within one or five percent with the Yates corrected chi-square. These results are given in Table 3 below.

Table 3: Percentage of midwives performing critical counseling tasks

Critical Skill	Learners observed performing this skill (N = 30) %	C-group observed performing this skill (N = 30) %
Assures confidentiality	93.3	46.4**
Facial expression, gestures and speech communicate caring, interest and acceptance	100.0	90.0
Pays attention to what the client was telling the provider and clients non-verbal cues (glances, gestures, bodily reactions, voice tones, pauses)	96.7	93.3
Asks about feelings	30.0	20.0
Asks about risk of STI/HIV	43.3	16.7*
Encourages client to talk	86.7	73.3
Gives accurate concise information requested by the client	90.0	73.3
Helps the client to identify decision areas and problems	86.7	66.7
Summarizes the discussion with the client	43.3	20.0
Lets client make the decision and refrains from offering solutions prematurely	80.0	76.7
Invites the client to bring or send others to the maternity home	83.3	10.0**
Thanks the client for coming and invites her/him to return to the maternity home	96.7	66.7**

* Difference is significant at $p < .05$

** Difference is significant at $p < .01$

The results presented in the table above show that for four of the twelve critical counseling skills the SDL learners were more likely to perform as desired than the non-participants performed. On the remaining eight critical skills, there was no significant difference between the two groups. In other words, the control group performed just as well or just as poorly as the learners on those eight skills did.

Critical skills on which learners scored better

The areas of difference are interesting. The SDL learners were significantly more likely to ensure confidentiality when counseling their adolescent clients. When deciding whether or not to award a "yes" on this matter of confidentiality, the research team was asked to determine that the mid-wife being observed had ensured that no one could hear or see the client during the counseling session. This "not hear, not see" rule for the observers was an easy short hand that allowed the researchers to measure the extent to which the learners had applied a key element from **Module 2: Counseling Adolescents**. In that module, learners are informed that an important aspect of the counseling process is "arranging a situation that the client believes is private, comfortable and confidential" (Module 2, page 10). Discussions with the facilitators and learners during the evaluation indicated that particular emphasis had been placed on this during the SDL course. As a result, many midwives rearranged their maternity home in order to provide a private space for counseling, in some cases incurring additional investment costs. This finding is particularly important because the assessment of GRMA providers conducted in April and May of 1997 had indicated a problem with privacy for counseling at many of the GRMA members private maternity homes.

It appears likely that the innovative training approach itself may have contributed significantly to improving privacy among the trained midwives. Unlike traditional training, in which participants leave their work sites for a week or a month, the self-directed learning approach allowed midwives to stay at their sites while studying and to receive regular visits from their paired learner and their facilitator. On site learning may have allowed participants to note potential improvements in their counseling environment. Visits from a fellow learner and from the facilitator may have helped the learner devise solutions to the need for increased privacy. Indeed, discussions with the facilitators during the evaluation indicate that they often assisted the learners in changing the work environment in order to improve quality. This result therefore suggests that the learner support system incorporated into the GRMA/PRIME SDL course was particularly important in reinforcing the learning process and encouraging application of the knowledge gained from the module.

Another critical item on which significantly more learners performed better was questioning the client to ascertain her risk of exposure to STIs or HIV. This was the subject of an entire module in the course: **Module 6: Providing STI/HIV/AIDS Services to Adolescents**. This module was the last module covered by the learners and it was completed during July and early August. A smaller proportion of the learner sample (13/30) was observed applying this skill than the previously mentioned privacy skill. Nevertheless, this number was significantly higher than the number of controls who also asked the client about STI risks, suggesting that the course may have had an effect on the application of STI/HIV knowledge when counseling adolescents. As with the improvement in

privacy, this result is important since the 1997 assessment had shown weaknesses in STI counseling knowledge among the midwives.

A significantly larger number of midwives performed as desired on two other critical skills: 1) inviting the client to bring others to the maternity home and 2) thanking the client for coming and inviting her to return to the maternity home. These actions represent more than courtesy and good counseling manner on the part of the midwife. First of all, planning a future visit with the client may be important depending on the problem identified or service offered. Secondly, a motivating force for the GRMA midwives, in addition to improving their skills and the quality of their services, was the desire to increase their client load and subsequent revenues. Operating in the private sector, the participating midwives in the SDL course expressed their enthusiasm throughout the course and evaluation for the idea that the new skills gained during the course would bring them new clients. Encouraging adolescent clients to recommend their services to others would have the potential to increase their client base. In addition, and more importantly from the point of view of reproductive health policy, by encouraging midwives to remind clients to send others to the clinic, the SDL course promoted wider access to RH for adolescents. By both encouraging clients to make recommendations and by holding community IEC sessions on ARH (another emphasis of the course), SDL-participant midwives attempted to send the message to young clients that services for them are available in the maternity.

Critical skills on which learners and controls score equally well or equally poorly

On the four critical skills just mentioned (creating privacy, ascertaining STI risk, encouraging the referral of other clients and thanking the client) the SDL participants were more likely to be observed applying the skill than the control group. As seen in Table 3 above, for most of the other critical skills (where there was no significant difference between the learners and the controls), a large majority of both the learner and the controls were observed applying the desired skill. Most SDL participants and most non-SDL participants are equally likely: to communicate that they care and are interested, to pay attention to what the client is communicating, to encourage the client to talk, to give concise and accurate information requested by the client, to help the client identify decision areas and to let the client make her own decision.

Both the learners and the controls performed poorly on two critical skills. Only a small number of each group, as the table shows, were likely to ask the client about feelings (9/30 of the learners and 6/30 of the controls) and to summarize the discussion (13/30 of the learners and 6/30 of the controls). As with the other skills discussed here, these are also included on the checklists in the SDL/CPI modules. It may be that the role-play situation used by the research teams did not lend itself

to probing the client about her feelings. A summary of the discussion, however, would be appropriate in any counseling situation.

Comparing Results on Non-critical Skills

In addition to the twelve critical skills discussed above and presented in Table 3, the observation tool included 20 other items (see instrument in appendix). For almost all of these a large majority of both the learner sample and the control sample were observed to perform the skill in question, with no significant difference between the two. There were a few exceptions to this rule, in two directions: on some items, learners performed significantly better than non-learners and on some others both groups performed poorly.

Other skills on which learners performed better than controls

Significantly more learners (28/30) than non-learners (20/30) made sure the counseling environment was private and comfortable ($p < 0.05$). This is of course linked to the earlier finding described above that significantly more learners assured confidentiality. In addition, significantly more participants (29/30) than controls (21/30) used flipcharts, models or samples when explaining medical information to clients ($p < 0.05$). In explaining issues relevant to an adolescent client, significantly more learners were likely to discuss sexuality: 13/30 among the learners as compared to 4/30 among the controls ($p < 0.05$). More learners (28/30) than non-learners (8/30) explained contraceptive usefulness for young clients ($p < 0.01$) and more learners (27/30) than controls (18/30) discussed STIs/HIV/AIDS ($p < 0.05$).

Other skills on which neither group performed well

There were also some skills on which both the learner sample and the control sample performed equally poorly, with no statistically significant difference between them. A majority of both learners (22/30) and non-learners (27/30) did not discuss policies related to adolescents. A majority of learners (23/30) and of controls (28/30) also failed to discuss physical changes during adolescence with their client. Similarly, a majority of learners (19/30) and of non-learners (26/30) failed to discuss relationships with the client.

Conclusions on Observation of Counseling by Learners and Non-Learners

Direction of results overall

Leaving aside questions of statistical significance, it is noteworthy that the observation results consistently show a relationship in one direction: the SDL learners' sample always scored better than the control sample. Even taking into account the methodological concerns cited earlier, this consistently positive relationship reinforces the overall conclusion that the SDL participants perform better when counseling an adolescent client in a role-play situation. This is a result one would certainly hope to find, since the SDL/CPI initiative placed a major emphasis on counseling skills.

Main results

The results presented in this section can be summarized in seven points.

1. The SDL trained midwives exhibited better counseling skills in adolescent reproductive health in role-plays than those who had not had the training.
2. The SDL learners were significantly more likely to ensure confidentiality and to make sure that the counseling environment was private and comfortable when counseling their adolescent clients than the control group.
3. Significantly more SDL learners than non-learners asked questions of the client in order to ascertain her risk of exposure to STI or HIV and discussed with the client issues having to do with STI and HIV.
4. On two other critical skills a significantly larger number of midwives performed as desired: inviting the client to bring others to the maternity home and thanking the client for coming and inviting her to return to the maternity home.
5. For most of the other critical skills (where there was no significant difference between the learners and the controls), a large majority of both the learner and the controls were observed applying the desired skill. Most SDL participants and most non-SDL participants were equally likely to: communicate that they care and are interested, to pay attention to what the client is communicating, to encourage the client to talk, to give concise and accurate information requested by the client, to help the client identify decision areas and to let the client make her own decision.
6. For two critical skills both the learners and the controls performed equally poorly: probing the client about her feelings and providing a summary of the discussion.
7. For almost all of the other skills (not deemed critical) a large majority of both the learner sample and the control sample were observed to perform the skill in question, with no significant difference between the two. There were a few exceptions to this rule in two directions: on some items, learners performed significantly better than non-learners and on some others, both groups performed poorly.

Overall conclusions

The results of the observation of midwives during a simulated counseling session indicate that participation in the SDL/CPI initiative is associated with overall better counseling performance. Participation in the SDL/CPI initiative is also associated with a greater likelihood of ensuring confidentiality and privacy for the client, a key goal of quality of care improvements in reproductive health. Participation in the SDL course is also associated with a greater likelihood of addressing issues having to do with STI and HIV during a counseling session. Similarly, participation in the initiative is associated with a greater likelihood of discussing sexuality generally and discussing the usefulness of contraception to adolescents during a counseling session.

There remain some areas needing further emphasis to ensure that the learners have acquired and are able to apply new knowledge. For example, too few learners addressed physical changes during adolescence with their clients and too few asked the client how she felt about the subjects under discussion. However, the overall results of the performance simulation component of this evaluation are encouraging and suggest that the SDL/CPI initiative has been beneficial for both the participant midwives and their young clients.

Adolescent Reproductive Health Service Provision

Self-reported Services Offered to Adolescents

The midwives were asked, both before and after the SDL/CPI initiative, whether or not they offered any specialized services for adolescents. This information was solicited through the self-administered ARH Opinions, Practice and Knowledge Questionnaire. Since statistics on service use levels were not collected during this phase of the initiative, this information serves as the best indication of change in services associated with the initiative.

In order to compare the results before and after, a simple cross-tabulation of linked variables was performed for each question, comparing the proportion giving a certain answer at baseline to the proportion giving that answer at follow-up. The differences between these proportions were tested using the McNemar test (a non-parametric test applied to binary variables in linked data sets) to see whether or not a statistically significant change was observed. These results compare the before and after responses of the same individuals: midwives who participated in the SDL/CPI initiative and completed the baseline questionnaire and were also in the evaluation follow-up sample.

The results for services overall and for many specific types of services appear to indicate that there was a statistically significant increase in the number of midwives who said that they provide specialized adolescent services.

Table 4: Percentage of learners offering specialized services to adolescents

Question asked	At Baseline (N=28) %	At Follow-up (N=28) %
Are there any specialized services offered for adolescents [in your maternity]?	78.6	100.0*

* Difference is significant at $p < .05$

A larger number of midwives stated that they offer adolescent services after participating in the SDL/CPI initiative than before the initiative. In addition, 20/30 midwives among the control group indicated that they currently offer these services, significantly fewer than those who participated in the SDL initiative do. In addition, a significant change in the responses was observed when the midwives were asked before and after whether they offered a number of specific services to adolescents.

The results of this analysis indicate that when comparing the number of midwives who said that they offered specific adolescent reproductive health services before participating in the SDL initiative to the number who said that they did so after the initiative, there was a significant increase in many categories. Additionally, the follow-up responses for SDL participants were also significantly higher for many specific services compared to the control group of non-participants.

Table 5: Percentage of learners offering specialized services to adolescents by type of service

Specific service offered to adolescents	At Baseline (N=28) %	At Follow-up (N=28) %
Individual guidance and counseling	67.9	100.0**
Community outreach and education to adolescent groups	35.7	89.3**
Pills	53.6	89.3**
Injectables	35.7	82.1**
IUD	46.4	75.0
Condoms	50.0	89.3**
Vaginal spermicides	46.4	85.7**
Emergency contraception	28.6	60.7**
Menstrual regulation / Abortion	10.7	28.6
Post abortion care	14.3	50.0**

Post female genital mutilation care	14.3	17.9
STI diagnosis and treatment	28.6	85.7**

** Difference is significant at $p < .01$

Statistics on Adolescent Client Levels

The instrument

The evaluation team designed a data collection tool to gather statistics on the use of services by adolescents during 1998 and 1999. Service statistics were collected monthly on the number of adolescent cases for: STI/HIV, postabortion care, emergency contraception, and new clients for condoms, oral contraceptives, IUDs, injectables and spermicides. In addition, the instrument included fields for the number of adolescents counseled, the number attending educational sessions and the number of educational sessions. The form was completed for each month of 1998 and for each of the first ten months of 1999. (See Appendix 8: Service Statistics Form.)

Methodology

Collection of service statistics was not included as part of the SDL program and pre-testing of this tool indicated that very few midwives collected this information. As a result, the evaluators were unable to collect these data and were unable to quantify the intervention's effects on service levels. However, as described in other sections of this report, SDL-trained midwives indicated in their comments that they felt that the initiative had helped them to attract new clients. In addition, as shown above, there was a substantial increase in the number of midwives reporting that they offered specialized adolescent services.

Further steps

Discussion of these findings during the presentation of preliminary results to representatives of GRMA and PRIME/Intrah resulted in the recommendation that data collection be included in the next phase of the project. Such data would allow individual midwives, as well as GRMA as a whole, to track the numbers of adolescent clients being served, and could be used as part of the monitoring process in the future.

Conclusions on services provided

It is clear, having asked the SDL learners both before and after the course about the adolescent services that they provided in their clinics, that RH services targeted to adolescents had increased. Although we do not have data on client levels, the midwives who participated in the SDL project reported that they had increased their services to adolescents after the training. Taken together with previously presented evidence of improved counseling skills, it seems likely that the quality and availability of ARH services have improved among participant midwives.

Knowledge and Opinions

The Instrument and Statistical Tests

The evaluation also sought to determine what effect the SDL initiative might have had on the midwives' knowledge and opinions about adolescent reproductive health care. In order to measure this information, participants were asked to complete a questionnaire before the start of the initiative and the sample of learners was asked to answer the same questions during the evaluation. Of the individuals in the sample, 28 had completed the baseline questionnaire, resulting in a sample of that size for the comparison of knowledge and opinions before and after the intervention. When comparing the linked variables (before and after for the same individuals) we use the McNemar test for binary variables to determine the probability that the result could have occurred by chance. In addition, the 30 midwives in the control group also completed this questionnaire and their results are reported for comparison purposes.

The ARH Opinions, Practice and Knowledge instrument was used to collect this information (see Appendix 4). This instrument addressed issues including family planning methods, policies on eligibility criteria, counseling, IEC, ARH, STI, emergency contraception, postabortion care, services and training. The tool yielded particularly useful information on knowledge about policies, technical issues and services offered. (Information on services was presented in the previous section.) Unfortunately, some questions contained in this instrument could not be analyzed. Specifically, for Questions 12, 14, 20, 21 and 22 the widely divergent interpretations of the meaning of the questions led to as many as 29 different responses. Asking Question 23 was not appropriate, as the subject matter did not appear in the course. The main effect of this is to leave the evaluation without useful information on how the midwives' knowledge of postabortion care was influenced by their SDL participation. In a sense, this evaluation has served as a pre-test of these questions and future evaluations may refine the questionnaire using this information.

The tool did allow us to make some important observations. Most importantly, the SDL course seems to have reduced eligibility barriers for adolescents and expanded the range of adolescent reproductive health services. In this section, we present the findings related to knowledge and policies.

Opinions

After having participated in the SDL course, significantly more midwives stated that there are no family planning methods that are particularly better than other methods. The nine members of the learner sample who said, "yes, some methods are better than others," volunteered different methods and reasons. (Each could cite up to three methods, so totals exceeded nine.) Six stated that the "IUD" was better, saying it was long acting and there was nothing to forget. Six said "injectables" were better, because they are long acting, cost-effective, reversible and easy to get. Three said the "pill" was better, because it is long acting and because it is reversible. Two said "sterilization" was better, because it is permanent. Two said

"Norplant® Implants" were better, because it is long acting. One person said "condoms" were better, because they prevent STI and AIDS.

When asked whether any FP methods are worse than other methods, only one person said "yes" after participating in the SDL course. She cited "withdrawal" as worse than the others, saying "it needs strong will power."

Table 6: Percentage of learners who report that no family planning methods are better or worse than other methods

Question and answer given	At Baseline N=28) %	At Follow-up (N=28) %
Are some FP methods *better* than others? No	46.4	67.9*
Are some FP methods *worse* than others? No	78.6	96.4

* Difference is significant at $p < 0.05$

The purpose of these questions was to determine whether or not the midwives harbored any particular prejudices that might influence the extent to which they prescribe methods or the manner in which they counsel about them. The results to do not give any cause for concern. On the contrary, a large majority of midwives believed that no particular methods were better or worse, indicating that they understood that the best method is the one that best matches the situation and needs of the client.

The midwives were also asked whether they "agreed strongly," "agreed," "disagreed" or "disagreed strongly" with two statements. The first statement was "A man should not use condoms with his wife." There was a slight change between the baseline and the follow-up responses to this question. Before the SDL course, two people agreed strongly, one agreed, 18 disagreed, and seven disagreed strongly. After the initiative, one person agreed strongly, two agreed, 12 disagreed and 13 disagreed strongly. Thus there was some movement towards disagreement with the statement, perhaps due to the STI/AIDS module in the course.

The second statement for which the extent of disagreement was sought was: "Married couples with less than three children should not be given a permanent method of contraception (that is, minilap/female sterilization or vasectomy/male sterilization). For this question, there was no observed change between the baseline and the follow-up. At the time of the baseline, two people agreed strongly, eight agreed, 12 disagreed and six disagreed strongly. At the follow-up, exactly the same numbers of people gave each category of response as at the baseline.

Eligibility Policy and Practice Questions

In addition to exploring midwives' general opinions regarding family planning methods, the evaluation sought to assess the midwives' adherence to the National Reproductive Health Policies and Standards, which include specific measures to reduce barriers to access. The results indicated that after the initiative, the

midwives were more likely to agree with the policies regarding parental consent, marital status and spousal consent.

Table 7: Percentage of midwives with knowledge of the national reproductive health policies and standards

Question and answer given	I-group At Baseline (N=28) %	I-group At Follow-up (N=28) %	C-group (N=30) %
Should a young, unmarried girl (for example between the ages of 10 and 15) be given a FP method *without parental consent*? Yes	89.3	100.0	80.0

When asked their opinion about parental consent when prescribing methods for adolescents, all of the participants in the SDL program agreed after the course that an unmarried adolescent should be given contraceptives without her parents' consent. Nearly all of the midwives expressed the same belief before the course so the SDL course did not produce a significant change. Justifications given after the course varied, with the largest group saying, essentially, that women have the right to make a choice. A few replied that it would be better to prevent an unplanned pregnancy and unsafe abortion. Others noted, simply, that the girl is sexually active, so it is best to give contraception. A couple stated that the parents' concern is not necessary and other midwives stated that an adolescent client should know what an adult client knows.

Asked to list family planning methods that should not be given to young girls, the midwives' opinions did not change significantly before and after the training. Beforehand, 22 of the 28 cited some methods, including IUDs, condoms, sterilization, pills and Norplant® Implants. Afterward, 19 of the 28 cited some methods, including IUDs, sterilization, female condoms, Norplant® Implants and withdrawal. The main change that should be noted is that after the intervention, neither condoms (male) nor pills were cited by anyone as inappropriate for young girls. However, after the intervention female condoms were indicated by some as not appropriate. IUDs and sterilization were most often cited as inappropriate for young girls, both before and after the intervention.

In response to this question, the evaluators had hoped for the answer that "all methods are allowed." It is possible, if perhaps unlikely, for a nineteen-year-old girl to have three children and want no more, thus making a long-acting method appropriate. But clearly even after the initiative, some midwives retained the idea that long-acting methods were not to be provided to "young girls." In addition, even after the initiative 19/28 midwives could think of some method they would not provide to an adolescent. Clearly, more work needs to be done in this area.

When asked if they require a woman to be married before providing FP, the midwives demonstrated a dramatic change after the SDL initiative, with all but two

saying "yes," before the initiative, and all saying "no" afterward. A large percentage of the control group also replied "no" for this question. This change may be due to a nation-wide MOH effort to disseminate the policies and standards during the same period as the SDL course was underway. When asked if they require spousal consent for providing family planning, midwives were more likely to respond "no" after the training than before. Trained midwives were also more likely to respond "no" than the control group. The two respondents, who indicated that they would require spousal consent after the training, indicated that this would be for female sterilization and male sterilization.

This finding suggests that the SDL course may have exerted influence beyond that of the straightforward dissemination of the national policies and standards. While both learners and non-learners have heard the message about marital status, learners were significantly more likely to report that they did not require spousal consent to provide a FP planning. This may well have been as a result of the reinforcing effect of discussions during paired learner sessions and peer review meetings.

When asked if they required the presence of menses for initial prescription of some methods, a small number of midwives replied "yes" both before and after the initiative. While the correct response would be "no," 8/28 cited IUD, pills, injectables and Norplant® Implants as requiring the presence of menses.

Asked about examinations of the client, the same number (16/28) responded that they did conduct exams for certain methods both before and after training. The correct response would have been "yes" for the IUD, injectables, Norplant® Implants, pills and tubal ligation as the methods requiring exams. However, the number who replied "yes" to the question did not change after the intervention. The 16 who replied "yes" did correctly cite the IUD, the pill, injectables, and female sterilization as methods requiring an exam.

Table 8: Midwives' opinions on selected eligibility criteria

Question and answer given	I-group At Baseline (N=28) %	I-group At Follow-up (N=28) %	C-group (N=30) %
Do you require that a woman be married before initial prescription of FP methods? No	7.1	100.0*	96.4
Do you require spousal consent before initial prescription of certain FP methods? No	60.7	92.9**	56.7**

Do you require the presence of menses for initial prescription of certain FP methods? No	28.6	28.6
Do you require physical, gynecological and laboratory exams before initial prescription of certain FP methods? Yes	57.1	57.1

* Difference is significant at $p < .05$
** Difference is significant at $p < .01$

Counseling Knowledge Questions

When asked to define counseling and the skills required, the midwives who participated in the initiative did not differ significantly in the responses they gave to most questions before and after the SDL course. This is because a large number already knew the correct response before the course. There is, however, an overall increase in the number answering correctly and one question showed a statistically significant increase in correct responses. These knowledge questions about counseling are perhaps not as useful as the results of the observation of counseling presented earlier as the SDL course was designed to improve performance.

Table 9: Percentage of learners exhibiting correct knowledge about counseling

Question and answer given	At Baseline (N=28) %	At Follow-up (N=28) %
The following skills are all used in counseling *except*... Interrogation	71.4	82.1
Counseling is part of interaction between client and provider. True	92.9	92.9
Effective counseling requires appropriate interaction between client and provider. True	92.9	96.4
Effective counseling should be centered on the concerns of the client. True	50.0	71.4
We cannot proceed with effective counseling without client's perspective. True	39.3	71.4**

** Difference is significant at $p < .01$

Adolescent Reproductive Health Questions

There was no statistically significant change in trained of midwives' responses to a series of technical knowledge questions about adolescent reproductive health. Like the answers to the counseling questions above, however, a high percentage of midwives answered correctly at baseline. While statistically significant changes were not observed, midwives' responses improved in all but one category, which stayed the same. These improvements suggest that the course exerted a positive influence.

Conclusions regarding knowledge

Overall the findings regarding knowledge were less conclusive than the findings regarding counseling practice and range of services offered were, with one important exception: midwives who participated in the SDL initiative exhibited a better understanding of national policies regarding certain eligibility criteria after the training than they did before the training. In particular, trained midwives demonstrated an improved understanding that national policies do not allow a woman to be refused family planning services because she is unmarried or has not obtained the consent of her parents or her husband. In addition, learner midwives possessed a wider understanding of these eligibility criteria policies than did the control group of non-participants. This finding is important because it indicates that the SDL initiative has had an effect beyond that of the normal process used to disseminate policy and program information in the country. The self-study approach combined with the learner support system seems to have played a role in increasing midwives' retention of this information.

Table 10: Percentage of learners exhibiting correct knowledge about adolescent reproductive health

Question and answer given	At Baseline (N = 28) %	At Follow-up (N = 28) %
Which category of adolescents needs information on adolescent reproductive health? All of the above	78.6	85.7
Which of the following list of problems is *most* common to pregnant women under 20 years of age? Pregnancy induced hypertension and eclampsia	67.9	75.0
Which of the following topics can be discussed in an Adolescent Reproductive Health program? All of the above	85.7	85.7
During IUD follow-up care, a client tells you that she is HIV positive. She is happy with the IUD and has no problems: she requests your advice about continuing with her IUD. Your *best* advice to her is to... Continue with her present method and use condoms to prevent spread of infection.	92.9	100.0
How long after unprotected intercourse can a client start pills for EC?	60.7	85.7

72 hours		

There remain, however, other eligibility criteria and technical knowledge subjects for which insufficient numbers of midwives provided the correct response. These included whether menses must be present to prescribe certain methods and for which methods examinations or tests are necessary.

Views of Adolescent Clients

Sample and Methodology

In addition to observing and interviewing the midwives, the evaluation team sought to document the opinions of some of their adolescent clients. The adolescent clients interviewed for the study were identified by the midwives themselves and interviewed by a member of the evaluation fieldwork teams as described earlier. The interviews covered services received and level of satisfaction with those services (see Appendix 7: Adolescent Client Interview Guide). From the sample of 30 SDL course participant midwives, 23 adolescent clients were interviewed, 17 girls and six boys. From the control group of 30 midwives, 15 adolescent clients were interviewed, all girls. (The field work teams had been instructed not to expend too much time seeking client interviews, but instead to ensure that the other instruments were completed.)

For purposes of analysis, the adolescent girls are separated from the boys. Thus the 17 female clients of the SDL participant group are compared to the 15 female clients of the control group of midwives who did not participate in the initiative. The results from the six boys are reviewed briefly afterwards.

In general, the results show that the satisfaction with care of the female adolescent clients did not differ between the participants and the control group. This result could be due to two types of bias in the methodology. The first methodological issue that might have influenced the results is a selection bias resulting from the fact that the midwives themselves identified which of their clients would be included in the sample. Service providers are not likely to recommend to the evaluation team an adolescent client she knows to be dissatisfied. This would result in a positively biased sample for both groups. A second potential source of bias is known as courtesy bias and is commonly found in quality of care research when attempting to interview clients. No matter what the culture, clients are disinclined to criticize providers when questioned by survey data collectors.

It is possible that the results are not evidence of bias, but are instead a true indication of adolescent clients' views regarding the two groups of midwives. In this case the lack of difference between the SDL learner group's clients and the control group's clients would be a reflection of genuine satisfaction with the services provided by midwives. This would not be surprising, since the 1997 study of the GRMA midwives reported that the adolescents surveyed in the study liked and respected the midwives who ran the private-sector maternity homes.

Nevertheless, the evaluation team had hoped to find some additional effects of participation in the SDL initiative, which had a specific adolescent focus.

There is one exception, as will be shown below, to the overall finding of no difference between the two groups and that is in the area of privacy. When asked about the adequacy of privacy at the service site, more clients of the intervention group than clients of the control group midwives were satisfied with privacy. This was an explicit focus of the SDL course and as such is a positive finding from the evaluation.

Findings regarding adolescent female clients

The 32 female adolescents interviewed during the evaluation were aged between 14 and 19, with all but six being aged 17, 18 or 19. Slightly more of them were single than married or in a union.

Table 11: Characteristics of female adolescents interviewed

Age and Marital Status Groupings	Learner Clients (N=17) %	C-group Clients (N=15) %	Total (N=32) %
Aged 14 - 16	23.5	13.3	18.8
Aged 17 - 19	76.5	86.7	81.3
Single	76.5	40.0	59.4
Married or in union	23.5	60.0	40.6

The main reason expressed for the clients' initial consult at the maternity home initially was for antenatal care or delivery services (see Table 12). The next most common reasons for visiting the maternity were for family planning/infertility/reproductive health counseling or for family planning methods. A few visited for STI treatment or postabortion care.

Table 12: Female adolescents' main reason for visiting the maternity

Main Reason for Visiting the Maternity	Learner Clients (N=17) %	C-group Clients (N=15) %	Total (N=32) %
Antenatal or delivery care	23.5	66.7	43.8
Counseling on FP/RH or infertility	23.5	26.7	25.0
Family planning method	23.5	6.7	15.6
STI treatment	17.6	0.0	9.4
Postabortion care	11.8	0.0	6.3

The clients reported receiving a range of services from the midwives (not necessarily on one visit), including antenatal care, counseling and contraception (see Table 13).

Table 13: Services received from midwives by female adolescents

Services Actually Received from Midwife (multiple responses)	Learner Clients (N=17) %	C-group Clients (N=15) %	Total (N=32) %
FP Counseling	58.8	40.0	50.0
Family planning method	41.2	20.0	31.2
Postabortion care	11.8	6.7	9.4

STI treatment	11.8	0.0	6.3
Other (mostly ANC)	47.1	66.7	56.3

Asked to indicate whether they were very satisfied, satisfied, somewhat satisfied or dissatisfied with services received, all respondents in both groups reported that they were either very satisfied or satisfied.

Table 14: Female adolescents' level of satisfaction with services received

Level of Satisfaction	Learner Clients (N=17) %	C-group Clients (N=15) %	Total (N=32) %
Very satisfied	70.6	86.7	78.1
Satisfied	29.4	13.3	21.9
Total	100.0	100.0	100.0

When asked what specific characteristic of the midwife's treatment contributed to their satisfaction, most teenagers in both groups made comments that can be grouped under the headings "She received me warmly" or "She was polite, gentle and patient", as shown in Table 15.

Table 15: Female adolescents' reasons for satisfaction

Reasons for Satisfaction: Type of Comment	Learner Clients (N=17) %	C-group Clients (N=15) %	Total (N=32) %
Warm reception	52.9	40.0	46.9
Polite, gentle and patient	29.4	46.7	37.5
Explained things well	11.8	6.7	9.4
Counseled on RH	5.9	6.7	6.3
Total	100.0	100.0	100.0

For example, one fourteen year old client of an SDL participant midwife who came to the maternity for antenatal care said[1]:

I was happy about the way she received me and talked to me. She pampered me and even gave me some gifts.

The adolescents were asked next what it was about the maternity home environment that made them satisfied. Most respondents cited neatness, privacy and a home-like feeling (see Table 16).

[1] See also Appendix 12 for comments from other adolescents.

Table 16: Clinic environment factors in client satisfaction

Clinic Environment Factors in Satisfaction: Type of Comment	Learner Clients (N=16) %	C-group Clients (N=15) %	Total (N=31) %
It is neat	37.5	80.0	58.1
Like a home	37.5	6.7	22.6
Privacy	25.0	13.3	19.4
Total	100.0	100.0	100.1

For example, a client of the control group midwives said[2]:

> *The beds are neatly arranged. The baby's cot is near the mother's bed so your baby is very close to you.*

Clients of the SDL learners group of midwives also appreciated the environment, saying[3]:

> *The clinic is like a home. You can walk in at any time and share your problems with the midwife.*

The adolescents were also asked how they felt during the visit about the way the midwife interacted with them. They provided a range of comments that are reported in Table 17.

Table 17: Female adolescent evaluation of midwife-client interaction

Feelings about How Midwife Interacted: Type of Comment	Learner Clients (N=14) %	C-group Clients (N=12) %	Total (N=26) %
She was polite and gentle which made me relaxed	28.6	50.0	38.5
She was patient and took her time to explain things to me	35.7	8.3	23.1
I felt free to ask questions and open up to her	28.6	33.3	30.8
I feel like she is my own mother	7.1	0.0	3.8
I had faith that she could help me solve my problems	0.0	8.3	3.8

[2] See also Appendix 12 for comments from other adolescents.
[3] See also Appendix 12 for comments from other adolescents.

For example, SDL learner midwives' clients said[4]:

> *She was patient with me, took her time to explain issues to me. She asked me questions and also answered all my questions.*

Control group midwife clients said[5]:

> *She has time for me and explains things in such a way that you understand everything. She gives enough information and allays all your fears. You are always welcome. All of my friends and myself have brought our other friends here.*

The adolescents were then asked a series of specific questions about their experience with the midwife to which they could give only a yes or a no answer. As shown in Table 18 below, on one of these questions, having to do with privacy, there is a statistically significant difference between the two groups.

[4] See also Appendix 12 for comments from other adolescents.
[5] See also Appendix 12 for comments from other adolescents.

Table 18: Female adolescents' perception of their interaction with the midwife

Question Asked	Learner Clients (N= 17) %	C-group Clients (N = 15) %
You were comfortable asking questions	100.0	73.3
You received the right amount of information	88.2	73.3
Other clients could not hear your conversation with the midwife	100.0	80.0
You were treated politely by the midwife	100.0	100.0
Privacy was adequate during the visit	100.0*	66.7*

* Difference is significant at $p < .05$

The adolescent clients were asked at the close of the interview: "Would you recommend the midwife you saw to a friend?" All of the control groups clients and all but one of the SDL learner groups clients said they would. Asked then to give the reasons they would recommend sending a friend there, most said something about the good reception they experienced or about the fact that they were satisfied with the counseling or treatment they received.

For example, the clients of the control group of midwives said they would recommend the maternity to a friend because:

Everything she did was well done. The place is very neat and she respects me so I know she will respect my friends too. She is a very nice lady, speaks very softly, and is very kind.

The SDL learners' clients would recommend the midwife because:

I will recommend her because I think if I had seen her earlier I would not have had the problem I had. In fact, I nearly died. After treating me, she took interest in me and talked to me about family planning, STI and the complications of abortion. She is a friend to the adolescents.

Table 19: Reasons female adolescents would recommend sending a friend to the maternity home

Reasons for Recommending the Maternity to a Friend (multiple responses possible)	Learner Clients (N=16) %	C-group Clients (N=15) %	Total (N=31) %
Good reception	37.5	53.3	45.2
Satisfied with services	37.5	26.7	32.3
She is a friend to adolescents	25.0	13.3	19.4
Helped me with my family planning method	6.3	6.7	6.5
She has enough knowledge on ARH	6.3	6.7	6.5
She is patient and respects others views	6.3	6.7	6.5
Explained things to my understanding	6.3	0.0	3.2

Findings regarding adolescent male clients

There were six male adolescent clients interviewed, all clients of the SDL learner midwives. It is not possible as a result to compare them to a control group, but a brief summary of their responses during the interview are presented here.

Of the six, two were aged 17 and four were aged 19. All were single. Their main reasons for attending the clinic to see the midwife were for counseling (4 of them) or for STI treatment (2 of them). The actual services they received were counseling (4/6), a family planning method (3/6), and STI treatment (2/6). They all said they were "very satisfied" when asked to say how satisfied they were with the services they received. When asked what specifically made them satisfied, they commented on the warm reception they received (4/6), on the fact that the midwife had counseled them (2/6), or on the fact that she was patient, explained things well and provided a good service. Asked to describe what elements of the environment of the maternity home contributed to their satisfaction, they commented on the neatness (3/6) or the fact that it felt like home (2/6). Asked how they felt about how the midwife interacted with them, all made positive comments indicating that they felt comfortable asking questions and that the midwife was polite and took her time to explain things. All six of the respondents said "yes" to each of these six statements: You were comfortable asking questions; You received the right amount of information; Other clients could not hear your conversation with the

midwife; You were treated politely by the midwife; Privacy was adequate during the visit. All six of the respondents also said that they would recommend the midwife to a friend, giving as their reasons a range of positive statements having to do with how well they were received and treated.

For example, one nineteen year-old said he would recommend the midwife to a friend:

> *...because she treated me politely and really had time to tell me how to avoid STI. I was very impressed. I therefore joined the youth club she has formed and I have brought a lot of my friends to the club. I also tell others who have problems to go and see her.*

A seventeen year-old, said:

> *She is really a mother to adolescents so I will recommend her to any adolescent who needs help.*

Another seventeen year-old said:

> *The education she gave me on family planning is helping me very well. So I will always recommend her to my friends whenever they need such services.*

Conclusions regarding adolescent clients' views

Overall, there is no difference in the way adolescent clients of participants in the SDL initiative perceive the midwives or their services when compared to adolescent clients of midwives who have not participated in the training. As discussed in the first part of this section, this lack of a difference may be due to very common methodological biases that occur in this type of research. However, on one point, that of perceived privacy, the clients of the SDL participants are significantly more likely to say that the amount of privacy was adequate. Improving privacy for adolescent clients was a key element of the SDL course. Participants reported making changes in the layout of their clinics to improve privacy, as well as taking care to make sure counseling sessions are not overhead, in accordance with the knowledge gained from the SDL course. The adolescent clients of the SDL learners appear to have perceived this improved privacy.

Assessing the SDL Approach and the Implementation Process

It is encouraging to find that the SDL initiative had a positive effect on midwives' skills and range of services offered. However, demonstrating that achievement was not the only purpose of this evaluation. The evaluation also aimed to find out what stakeholders thought of the SDL approach and how well the process of implementation had gone. This section covers those topics.

The information about the implementation and the SDL approach presented in this section comes from two groups of sources. The first set of information comes from the learners themselves, from interviews conducted with the sample of learners during the follow-up evaluation, and from forms completed by the learners after each module. The second set of information comes from in-depth interviews with the GRMA Executive Director, the SDL Coordinator and the six SDL facilitators. In order to make the best use of the range of opinions and individual voices

emerging from these qualitative sources, the information gathered is presented in great detail. The conclusions, and linked recommendations, can thereby be seen to result from the views presented here.

Overall, the evaluation uncovered no major problems and everyone expressed enthusiasm about the SDL approach. As the discussion at the end of this section will show, there are a few implementation issues consistently raised by those being interviewed. However, these are all relatively minor.

Views of the Learners

Interviews with the Learners

The sample of thirty midwives who participated in the SDL initiative were interviewed during the evaluation to determine their views regarding this innovative training approach. The questionnaire covered the following areas:

- Adequacy and effectiveness of the learner support system
- Availability of materials and job aids
- Use of materials/Application of learning
- General information

Learner support system

On the whole the learners were appreciative of the support system they had for the SDL program. Questions were asked on the three components of the learner support system - Paired learning meetings, Facilitator visits, and Peer review meetings.

Paired Learning meetings

When asked what learners thought about the amount of time spent during their paired learning meetings, 27 out of 30 thought the amount of time (two-three hours) or sometimes up to four hours spent with the paired learner was adequate in terms of achieving their learning objectives. Some of the respondents further explained that:

> *The time depends on us because we always decide on the amount of time to be spent on a particular day and we are able to discuss any problems that we have had.*

> *I chose my own time, which is usually my off days, so that I could spend any amount of time with her and we were able to discuss our problems to our understanding.*

On the frequency of the paired learning meetings (once per month) the majority of respondents (24/30) thought it was enough, although some arranged with their partners to meet more than once in a month.

> *We meet once weekly so I think it is all right.*

> *We meet twice in a month so I feel it is enough and more so we are able to discuss our problems.*

For the remaining six learners, the frequency was a problem. They explained that[6]:

> *Because of the distance between me and my paired learner we are not able to visit each other quite often, if we could visit each other more than we did I think I could learn more.*

[6] See also Appendix 13 for comments from other learners

> *In some of the modules the topic is new to you so you don't really understand it the first time you handle it so if we could meet more frequently I think it can help us to understand the topics very well.*

When asked how they felt about being paired with the same partner for all of the modules, 21/30 said it was helpful in terms of helping them to achieve their learning objectives. The rest were of the view that partners could either be changed or their number increased. The different opinions expressed are as follows[7]:

> *I started with that person and we became well acquainted and understood each other so if it is changed it might not be like that so I feel having one partner throughout was all right.*

> *I would have preferred a change because various people have different ideas, so that by the end of a module I would have different views. But when we decide to rotate then there is the problem of expenses.*

Facilitator visits

A majority (25/30) of the learners said the monthly visit made by their facilitators to paired learners was adequate. The duration of the visit varied depending on a number of factors. According to the learners, facilitators spent on average two to three hours when they visited. 28/30 felt the amount of time spent with facilitators was sufficient. However, if a partner was late or if a paired learning activity took place on the same day, then the duration was extended.

We spend about five hours if we had the paired learners meeting the same day so after I spend two hours with my partner than the facilitator comes in to help us.

On the question of whether learners felt comfortable discussing issues with their facilitators, all of the midwives responded "yes." Some of the reasons given included[8]:

> *She is very nice with me and anything I don't understand she makes sure she explains to my understanding*

> *Our facilitators were two, and one was actually a tutor so she could really explain things to us. Both were really helpful. They alternated their visit. The second one actually pointed out important areas to tackle and concentrate on to us.*

Peer review meetings[9]

Almost all (29/30) of the learners indicated that holding the peer review meeting once in a month was frequent enough. The main reason given was that:

[7] See also Appendix 13 for comments from other learners
[8] See also Appendix 13 for comments from other learners
[9] See also Appendix 13 for comments from other learners

> *... once in a month so we do not have to be leaving our clinic very often for the peer review meeting.*

A majority of them (22/30) felt the duration was adequate and scheduling the peer review meeting on the same day as the general regional meeting was widely preferred as a way of saving time and money. However, most learners indicated that there were problems or disadvantages when the general regional meeting was scheduled for the morning and preceded by the peer review meeting.

Different views were expressed on when they thought the peer review meeting should be held. Most maintained that it should still be held on the same day as the general monthly meeting, but others suggested a separate day.

Asked which of the components of the learner support system they found most useful, 12/30 said the paired learner meetings. Some of the reasons they gave were as follows:

> *When I have studied on my own thinking I have understood the lessons, when I meet my pair I see that I get the understanding more than I did alone so I think it was very useful.*

> *...my paired learner lives very close to me so we do easily access each other whenever we need clarification.*

Another 12 mentioned the peer review meetings as the component they found most useful.

The remaining six who selected facilitator visits as the most useful component of the learner support system for them revealed that:

> *Facilitator was very knowledgeable and I learnt a lot from her.*

> *After I have studied on my own and also with my partner, I may still have some problems with the lesson but when the facilitator comes she explains very well to my understanding.*

Job Aids and Materials

Questions asked about the availability of job aids and materials showed that all 30 learners had the penis model by the time they started to work on the counseling module. All but one had received the family planing flipchart and contraceptive samples before beginning that module.

On the issue of what reference materials they had on hand, the following was found:

Table 20: Percentage of midwives with reference materials on hand

Reference Material	Learners having material (N=30)
Poster Policy/standards	86.7

Policy/ Standards summary sheet	96.7
Population report on GATHER	73.3
Guidelines for STI management	96.7
Pamphlet on Condom use	43.3
Outlook on Adolescent RH	56.7

Use of Materials/Application of Learning

Reference Materials

In describing the extent to which the reference materials helped them to plan and apply their learning, most of the respondents found the reference materials very useful and said that they used them[10].

> *I used them, in counseling adolescents, and educating the community on adolescent reproductive health.*

> *For eligibility criteria if I am doubtful I refer and am able to render family planning service confidently.*

However, six out of 30 had never used some of the reference materials. Those who mentioned what they had not used said:

> *All the materials... [because] immediately after the SDL program I felt sick and have not fully recovered up till now so I am not yet working.*

> *Those pertaining to women I hardly use...[because] I have only attended to three women.*

> *Family planning methods and services [materials], because I did not understand it well. So I can't use it. Please can you explain it to me?*

Schedule and Activity Plan

The schedule and activity plans were confusing to learners especially at the beginning. Though there have been some improvements, many still have difficulty filling them in. A review of each module's schedule revealed that some important activities were not completed as required. The table below shows the number of learners who scheduled the activities.

Table 21: Percentage of learners who scheduled the activities

Module Number	Paired Learning meeting (N=30)	Preparing for peer review meeting (N=30)	Completing the activity plan (N=30)	Peer review meeting (N=30)

[10] See also Appendix 13 for comments from other learners

2	73.3	46.7	50.0	63.3
3	73.3	50.0	53.3	56.7

Asked why those activities had not been scheduled, respondents gave reasons such as lack of understanding, time constraints and forgetfulness[11].

> *I haven't been carrying out all these activities but I did not know I have to write them in the activity plan. My facilitator even came to look through the books but did not say anything. I had a lack of understanding of its purpose.*

When asked what would have helped them complete all the schedules and include the four expected activities, many respondents said constant reminder from facilitators and good knowledge and understanding of why and how to fill it in would have helped.

Some learners had not completed activity plans in the different modules. Half of the learners (15) had not completed an activity plan for module 2; 14/30 had not completed it for Module 3 and 19/30 had not completed the activity plan for Module 4.

[11] See also Appendix 13 for comments from other learners

Adolescent Reproductive Health Activities Undertaken by Learners

However, learners who had completed the activity plans were able to carry out many adolescent focused activities. The following are typical comments from some of those who said they had undertaken special actions as a result of the SDL course[12].

> *I have made a sign board advertising adolescent services. I have created a place of privacy for adolescents. I have formed an adolescent club.*

> *I rearranged the furniture in the consulting room for privacy. I also used one of the classrooms of the nursery school in the house for meeting with the adolescents in the evening. I also formed a youth club made up of apprentice hairdressers, seamstresses, fitters and other adolescents in the area.*

The table shows the number of the sample of 30 SDL participants who had carried out specific activities as a result of the course.

Table 22: Activities performed by SDL participant midwives due to training

Activity	Learners (N=30) %
Counseling of Adolescents	93.3
Group talks/discussion with Adolescents	90.0
Group talk in community	73.3
Meetings with community members	40.0
Meeting with parents	20.0
Refer Adolescents for other services not available at her service site	36.7
Conditions to assure privacy (such as a private room for counseling)	33.3
Advertising Adolescent services on signboards	33.3
Special hours for adolescents	33.3
Reducing fees for services	3.3

With regards to the application of CPI / counseling skills, almost all (29/30) reported that they were able to apply the necessary skills.

Factors Influencing Participation in SDL

[12] See also Appendix 13 for comments from other learners

When asked what facilitated their participation in the SDL course, the midwives gave a variety of responses including: their interest in the program; the interest showed by the adolescents; facilitator, paired learner's meeting and peer review meetings; the modules; other reading materials; and the method and approach[13].

I had interest in the course so I will say it was self-motivation.

Reading materials helped me to be reading. Paired learner helped to study and to discuss issues. The facilitator helped to clarify areas of difficulty to establish understanding of areas in the module. Peer meetings helped those with problems to discuss it for clarification, which benefited all of us.

The schedule and self-study really helped me in participating in the course

The module job aids and posters and flip charts helped me a lot. I pay particular attention to health news and issues discussed on radio my interest in learning has increased.

I managed my time well to have time for the self-study. I also tried to practice what I had studied.

The interest that the adolescent showed encouraged me to learn more.... Formerly adolescents cannot come forward to me, now they come freely.

On factors that hindered their participation, most said nothing had hindered them. Others mentioned: time conflicts; interruption from clients; emergency cases; and social activities[14].

Time factor, because wherever I am I have to schedule my time to go to peer review meetings, meet my facilitator. Even if I am ill I have to make the time.

Interruption from clients during the paired learners meeting. My partner lost her husband so we could not meet for some time. I was also sick for sometime.

Orientation

The learners were asked, having completed the SDL program, to what extent did the orientation prepare them for their work with the modules. Of the 30 in the sample, 28 had attended the orientation. 14/28 felt that the orientation had prepared them well. 13/28 felt it had prepared them somewhat. One person felt it did not prepare her at all. Asked then what could have been done to improve the orientation, most participants felt it needed to be longer to cover the material.

[13] See also Appendix 13 for comments from other learners
[14] See also Appendix 13 for comments from other learners

If we were in smaller groups it would have been better. Sitting arrangement was poor, we were too congested, the room was too small and it caused conflict between participants. Three days would have been better.

Information about the workshop should be given far ahead of time and what we were going to discuss should be indicated.

It was a crash program and the period was too short, because at the end of the orientation I was not well equipped for the program.

Extend the period to four days so that those of us who are old would understand it. We did not understand the whole thing, same applied to my partner we were some how confused. If we are sent some reading materials in advance we might have been able to understand the orientation better.

Confidence with and Benefits of SDL Program

After completing the SDL program, all but one learner in the sample felt confident with completing a self-assessment form. All 30 learners in the sample indicated that they felt confident with the other components namely: performing a self study of the modules, putting what they learned into practice during paired learning meetings, interacting with facilitator during visits, and participating actively in peer review meetings.

Asked what were the benefits of participating in the SDL program, the participants made a number of positive comments[15].

Formerly I ignored adolescents thinking they are not matured but now with the SDL course I know it is very important to open my doors to them and give them counseling on STI/HIV/AIDS and other RH issues.

It has increased the number of my clients, the adolescents have now become my friends and they come to me anytime for counseling. It has helped me to learn on my own. It has increased my knowledge.

Before the program I felt the need to go into the community to talk to adolescents but did not know how to approach them, but now I can talk to them with ease and I do not frown on adolescent sexuality any more.

Now I can talk to adolescents without shouting at them as I use to do. Now I also respect them. Previously, I was judgmental. Previously I angrily refer them to hospital without counseling them. Now I have time and sympathy for them. I like to manage STI cases better so that they do not spread infection. Formally we were referring them instead of treating them. I am very happy I have gained a lot of

[15] See also Appendix 13 for comments from other learners

knowledge. Previously I was hardly giving talks to adolescents unless I'm invited now I request it myself.

Recommendations of Learners

When asked if they would recommend that SDL be used for future continuing education programs, all 30 midwives in the sample responded "yes." The midwives were also asked to make recommendations for improving the program before it is offered again. Some felt no changes were needed, but others made a range of suggestions regarding the length of the overall program and of the orientation meeting; the facilitators' visits; and the paired learning. They also recommended that the SDL program be extended to other midwives and to other health topics.

Extend program to other midwives, as others are very interested. But increase the partners - pair learners to three instead of two because three heads are better than two.

Every midwife should be given the chance to part-take in this program, I also recommend that the period for orientation should be extended.

If possible antenatal, immunization and child care should be included in the module.

I think the next time it is offered the program should not be clumped together. It should be done in bits. The six modules were too much for three months. When that is done I feel the result will be far better.

Module Evaluation Forms

At the end of each module is an evaluation form to be completed by the learner. These forms were collected by the facilitators and passed on to the Coordinator to be held until the final evaluation. This section provides a detailed summary of what the participants said on these forms, module by module. (Note that Module 1 is the introductory module that had no evaluation form. The substantive information begins in Module 2, along with the use of an evaluation form.)

Number of evaluation forms received

There were 59 participants originally selected to be learners in this initial phase of the SDL/CPI initiative, however the number of module evaluation forms received varied between 52 for the first set (for module 2) through 44 for the final set of evaluation forms (for module 6).

Table 23: Number of evaluation forms received by module

Module Number	Number of Evaluation Forms Received
2	52
3	47

4	47
5	45
6	44

Description of and comments regarding the evaluation form

The module was evaluated using an identical form. There are 15 statements for which the learner ticked a yes or no answer. For "no" responses, the learner was asked to explain their answer. In addition, at the end of the form there are three open-ended questions. (See example of form in appendix 14). Not all those who ticked "no" to a given question explained their answer while some enthusiastic learners who answered "yes" nevertheless gave comments in the column although this was not requested. In addition, learners occasionally made comments that were not directly related to the statement to which they had answered yes or no. In some places this confusion makes it difficult to understand the meaning of the comments made.

In addition, some of the statements on the evaluation form itself are somewhat ambiguous in meaning. For example, the second statement asks whether "The amount of content and length of activities is appropriate" and follows directly on one asking whether or not the learner was able to complete the task in the time given. Comments on this second statement indicate that it was interpreted by at least some respondents as another way of asking about the length of time needed.

The fifth statement was "The content is stated simply and clearly and corresponds to my job responsibilities." Comments on this statement indicate that some people reacted to whether or not the content was simple and clear while others reacted to whether the content reflected the midwives' job responsibilities. These subjects might best be separated into two statements.

The eleventh statement was "The information and practice is adequate for having an effective meeting with my partner." Judging by the comments, most negative responses to this question did not have to do with the module, but rather with other obstacles to meeting with the learners' partner.

The twelfth statement, "I was able to complete the module without assistance," was also interpreted in various ways by the learners. Some respondents seemed to indicate with a "no" response that they could not complete it at first, but could after receiving assistance from their partner or facilitator. Others respondents seemed to indicate they could not complete the module but were unclear on whether they needed more time or wanted more assistance.

These observations about the evaluation form itself indicate that there are some areas of confusion making some of the information on the forms difficult to interpret. Improvements to a future form could correct these matters.

Nevertheless the forms do provide some useful information, and much of it is corroborated by information gathered from other sources during this evaluation.

This section first provides a summary, module by module, of the evaluation forms. All of the information provided by the evaluation forms is presented here. Thus, if no comments are presented despite a number of "no" responses, this means that no explanatory comments were given. At the end of this section, a summary is given of the key findings from all of the evaluation forms taken together.

Module 2

For Module 2, 33 of the 52 respondents said that they were able to complete the module on time. Of those who said they were not able to complete on time, 12 people gave comments as to why. Eleven of these gave reasons that reflected a lack of time to finish due to client interruptions, other workload and family interruptions. One person said she was called away to a workshop during that month and so could not finish. Forty-three of the 52 respondents felt that the amount of content and length of activities was adequate. Of those who disagreed, four commented, expressing "a lack of time."

All of the 52 agreed that the content responded to the stated objectives and 47/52 agreed that it was sequenced logically. Two commented that "the checklist seems to be repeated too many times." Forty-nine of 52 agreed that the content was stated simply and clearly and corresponded to midwives job responsibilities. Two stated "some contents are difficult to understand." Forty-eight of 52 agreed that the text was clear, legible and easy to read, but those who disagreed did not comment. Forty-five of 52 agreed that the instructions were easy to follow. Of those who disagreed, two gave comments. One said the instructions were a bit complicated and one said she did not understand the instructions. Fifty of 52 agreed that "the self-assessments help me identify my knowledge and skills gaps and help focus my attention on important information," and one person added enthusiastically that it "helped me to study a lot." All the 52 agreed that the suggested activities helped reinforce the learning, and one added the positive comment that the "learning has improved my knowledge." Fifty of the 52 agreed that the readings respond to the stated objectives, but the two who disagreed did not comment. Forty-nine of the 52 agreed that the information and practice is adequate for having an effective meeting with their partner. Two respondents who disagreed stated that they had difficulty getting transport to meet with their partner (a problem not really associated with the content of the module).

In reaction to the statement "I was able to complete the module without assistance" most replied "no." Thirty of the 52 said they were not able to complete the module without assistance. Of these, 19 people made comments. Eight stated that they had to be helped by the facilitator and three stated that they completed it with their paired learner. Six said they "could not understand some of the issues." One

said the time was too short, and one was away at a workshop and so could complete the module.

Thirty-eight of the 52 had all the materials available to complete the course, but only four of the 14 who disagreed made comments. Two said they did not have the AIDSTECH/FHI instrument. One said she needed further information on physiological changes during puberty and one said she needed further information and materials on adolescent reproductive health.

Thirty-six of the 52 agree that they were able to receive all necessary help from their facilitator if or when they needed it. Of the 16 who were not able to receive this help, ten made comments. Seven said simply that the "facilitator could not visit" or the "appointment date was not met." Two stated that the facilitator was at a workshop. One person added a positive comment: "The facilitator helped a lot."

Fifty-one of the 52 agreed that they would apply new knowledge and skills in their workplace. It is unfortunate that the one person who stated "No, she would not apply this new knowledge," did not comment or explain why. However, one person made a positive comment, indicating that she would apply the new skills in order "To win more clients and prevent STI."

When asked what they liked best about this module, the learners made a wide range of comments. Eleven respondents particularly liked the elements on counseling. Ten people liked that the module improved their knowledge and skills of ARH and nine commented that it had improved their learning and reading skills. Six people liked that it helped to identify gaps in their knowledge and skills of ARH. Five people said they liked "everything in the module." Two people said they liked the *Population Reports* reference. Two people liked "to come out with an activity plan." Once person each said that she liked: that the module gives knowledge prior to the assigned activity; that it gave self-confidence; that it helped in re-structuring the work environment; the activity number 5; the exchange of ideas; and the role play.

Asked about problems encountered, most made no comment or said they had no problem (37 of the 52). Of the fifteen who noted problems, the largest number seven noted that they could not complete the module due to limited time. Five said they did not understand some of the instructions. Two said they had problems but discussed them with their paired learner. One respondent noted the role-play on page 30 (a difficult scenario involving rape).

Asked to add further comments or observations, 47/52 had nothing to add. Five people made these five comments: manual was not well bound; the traditional and cultural background of the client should be considered, especially greeting and establishing rapport; more materials needed on adolescent reproductive health system; should go for refresher courses; and improvement in knowledge.

Module 3

For Module 3, 39 of the 47 people who turned in forms said they were able to complete the module on time. Three said that the "time allocated was not enough" and two noted they had experienced "a lot of interruptions." Two others were away attending a workshop. One person commented that the "learning was faster this time." Forty-three (43/47) agreed that the amount of content and length of activities is appropriate, but those who disagreed did not comment. All 47 agreed that the content corresponds to the stated objectives. All also agreed that it is sequenced logically, with two noting that it goes from known to unknown. Forty-six (46/47) agree that the content is stated simply and clearly and corresponds to the job responsibilities of midwifes, and two made the positive comment "to get more clients." Forty-six (46/47) also agree that the text is legible, clear and easy to read. However one said "but it takes more time." Forty-five (45/47) agree that the instructions are easy to follow, but two said the "instructions are not easy" and one said it "takes time to read through." Forty-six of the 47 agreed that the self-assessments help to identify knowledge and skills gaps and help focus attention on important information. Two of those who agreed made positive comments, one saying it "helps to identify weak areas" and one saying it is useful "to help adolescents and other clients." Forty-six of the 47 also agree that the suggested activities help reinforce learning. Three people made positive comments here. One said it "helps to improve reading skills" and two said it "encourages learning." Forty-six (46/47) also agree that the readings correspond to the stated objectives. Forty-five of the 47 agree that the information and practice is adequate for having an effective meeting with the partner. One commented that her partner had lost her husband. Three others made positive comments, noting that the partner meeting "helps in sharing ideas", that they had "worked together" and that they "had enough time to discuss the content."

Thirty-nine of the 47 said they were able to complete the module without assistance. Four people noted that they needed the assistance of their partner or facilitator, and one stated that "there were some interruptions." Two noted positively that the "contents are very understandable and easy to follow." Forty-two (42/47) agreed that they had all the materials needed, with three commenting that they had received materials from their partner or facilitator. Forty-six (46/47) agreed that they were able to receive help from their facilitator, and one commented that her "facilitator was always present when needed."

Forty-six (46/47) agree that they will apply the new knowledge and skills. The only comments are positive ones. One person said, "it will enhance my work." Three respondents said they were already "receiving more adolescent clients now."

When asked what they liked best about the module, 18 of the 47 did not comment. Seven (7) liked best the "RH counseling skills," another seven (7) said it had already improved their relationships with adolescents, and two (2) noted that they liked the fact that it identified gaps in their knowledge and skills for ARH. Five (5)

people said that they liked "everything about the module" and another five stated that they liked that "everything was simple to understand." One person said she liked "to come out with an activity plan," another said she liked "consulting with parents of adolescents to give IEC," and one noted she liked that it had improved her learning and reading skills.

Asked to indicate problems, most (40/47) said they had no problem or left the section blank. Two said they had problems, but were helped by the facilitator. One said she had problems due to interruptions, one noted ill health, one said she did not do questions 4-5, and one said it was difficult to meet her paired learner. One made a positive comment: "It encourages me to read always."

Only two respondents made further observations in the final section. One respondent noted the limited time to finish and one midwife requested posters of male and female reproductive anatomy.

Module 4

For Module 4, 35 of the 47 people who turned in forms said they were able to complete the module on time. Two of those who could not complete on time said the time limit was too short, three said they had been attending a workshop and one said her children had been ill. Forty-three (43) of the 47 agreed that the amount of content and length of activities was appropriate. Of the four who disagreed, only two made comments, one saying that there were too many activities in the module and one saying that there were too many brainstorming activities in the module.

All of the 47 respondents agreed that the content responded to the stated objectives. All of the respondents also agreed that the content was sequenced logically. Forty-six (46/47) agree that the content is stated simply and corresponds to the midwives job responsibilities, but one disagreed, stating that "some sessions difficult." Forty-six of the 47 (46/47) also agreed with all four comments: that the text is legible and clear; that the instructions are easy; that the self-assessments helped identify knowledge and skills gaps and helped focus attention on important information; and that the suggested activities helped reinforce learning. The one person who disagreed in each case did not comment.

Forty-three (43) of the 47 agreed that the information and practice was adequate for having an effective meeting with the partner. Three comments were made: one person said indicated that her partner lost her husband and two stated that they did most of the work with their ward assistant.

Thirty-four (34) of the 47 said that they were able to complete the module without assistance. Three of those who could not complete it alone said they received help from their partner or facilitator, one said the time was too short to complete it, and one said she was attending a workshop. The others did not comment. Forty-two (42/47) agreed that they had all the materials they needed. Three of these commented that their partner helped out with the materials and one stated that she

did have the materials but could not finish due to time. Forty-four of the 47 said that they were able to receive all necessary help from their facilitator, but no comments were given.

Forty-five people agreed that they would apply the new knowledge and skills, but unfortunately those who disagreed did not say why. One person who stated that they would apply the new knowledge made a positive comment: "in order to get new clients."

When asked what they liked best about the module, seventeen did not comment and seven said they liked "everything about the module." Six people said they liked the information about ARH and four said they liked the IEC activities. Three people said they liked the knowledge about counseling skills and another three stated that they liked the fact that the contents were very simple to understand. Two midwives said they liked that it identified weaknesses in knowledge and skills, two said that they liked that it kept them learning even at leisure times, and two more said that it helped to improve standards of work. One person said that it "helped in instilling time discipline into my activities."

Asked to indicate any problems, most (38/47) mentioned no problem. Of the rest, the largest number (5) said they found some questions difficult to understand. One said that she understood well when the facilitator "reads and explains instructions to me." One said she had difficulty in meeting her paired learner. One said she experienced interruptions due to sickness and one said she had "not enough time to concentrate."

Forty-two of the 47 had no further comments or observations. Two said they could not complete the module because they were at a workshop. One said she needed more time to complete some of the modules. One said that there should be enough posters and pamphlets on the topic discussed. And one noted positively that the program should be on going.

Module 5

For Module 5, 42 of the 45 respondents stated that they were able to finish on time, although two of these commented: "not strictly according to time." Two people commented positively that they were able to finish on time, one "because of answers provided" and the other because the module was "quite understandable." Two who could not complete on time said this was because of "ill health and the module arrived late" and because she "had difficulty due to work load."

All forty-five (45/45) agreed that the amount of content and length of activities were appropriate, with one commenting that "the instructions are quite understandable." All 45 also agreed that the content corresponds to the objectives. All but one (44/45) agreed that the content was sequenced logically, with the respondent who disagreed stating that there were "too many repetitions." All 45 also agreed that the content was stated simply and clearly and corresponded to the midwives' job responsibilities. Forty-four of the 45 agreed that the text is legible

and clear, with one disagreeing, saying "some tests are not clear." All forty-five also agreed that the instructions are easy to follow, but one commented that "some instructions are somehow difficult." Forty-four (44/45) agree that the self-assessments helped identify knowledge and skills gaps and helped focus attention on important information. One person commented that they were a revision of previous knowledge. Another respondent commented that they "could do better during sessions discussions." A third respondent noted that the "instructions are very easy to understand." All forty-five also agreed that the suggested activities helped reinforce learning, with two making the comment that "any available time is now used to read a little." All forty-five also agreed that the information and practice was adequate to have an effective meeting with the paired learner. However, one commented that "there were interruptions due to clients" and another commented that "due to ill health, the meeting was short." Two people commented positively that it improved their learning skills.

Forty-three (43/45) said that they were able to complete the module without assistance. Four commented that their facilitator and learning partner helped them. Forty-two (42/45) said they had all the materials. Of the three who did not have the materials, two said they were "looking for the posters to help complete the module" and one said she "did not do PAC." Forty-three (43/45) said they were able to receive all necessary help from their facilitator, with the two who were not simply commenting: "could not meet the facilitator as scheduled."

All (45/45) agreed that they will apply the new knowledge and skills in their workplace, and three added a positive note that they had: "already started." When asked what they liked best about the module, six left the section blank. Ten people said they liked PAC, six said they liked emergency contraception and six said they liked everything about the module. Five people said that they liked the knowledge about ARH and four said that they liked the knowledge about counseling skills. Three people said that they liked that the contents were very simple to understand. Two people liked the role-playing and one liked the IEC activities. One liked that it "helped identify gaps in knowledge and skills." One respondent noted happily: "This module helped me to understand the previous modules clearly."

When asked about problems, most people (38/45) either said they had none or made no note of any problems. Two said the facilitator solved all problems. Three people said the problem was with interruptions from clients, and one said she was "faced with so many obstacles." One noted as a problem that "it is a revision of previous knowledge."

When asked to make further observations or comments, 30 of the 45 respondents had no comment to make. Three people said, "SDL is educative so every midwife should be trained." Two said that the "pencils supplied were so soft and weak." Two suggested that the facilitators "should be given transport to ease their movement." Two noted that "since we are doing PAC, it would be better if we are

taught MVA in detail." Two others said that their counseling skills have helped to improve and increase their numbers of adolescent clients. One noted an "improvement in reading skills." One other said the "length of time for discussion on practical issues is not adequate, so a day should be set aside for it." One suggested that "the book should be portable to make it easy to carry." Finally, one respondent requested "diagrams for explaining abortion procedure to clients."

Module 6

For Module 6, 42 of 44 respondents said they were able to complete the module on time. Five people made comments, three saying they were not able to "go according to time table." One person noted interruptions and one said she had "difficulty answering some questions." All forty-four agreed that the amount of content and length of activities was appropriate, with one person noting this was "because of direct answers provided." All 44 respondents agreed that the contents correspond to the stated objectives and that the content is sequenced logically. All 44 also agree that the content was stated simply and clearly and corresponded to the midwives' responsibilities, although one person commented: "have to read through many times before you understand." Another respondent, however, noted positively that she "understood very well."

All 44 respondents agreed that the text was legible, clear and easy to read. All 44 also agreed that the instructions are easy to follow, with one person stating that "it helped to answer questions well." All 44 agreed that the self-assessments helped to identify knowledge and skills gaps and helped to focus attention on important information, with one person commenting: "especially how to deal with adolescents." Two other comments were made on this subject. One said it was a "revision of previous knowledge" and another said, "it makes you refer to your books always." All 44 learners agreed that the suggested activities helped to reinforce learning, with one person commenting that "it is a good lesson" and one commenting "it keeps me reading anytime I am free."

Forty-two of the 43 agreed that the information and practice was adequate for having an effective meeting with their partner, with two people commenting that "it helps to share ideas on our jobs." Thirty-eight of the 44 agreed that they were able to complete the module without assistance. Four people said they needed assistance from their partner or facilitator. Forty of the 44 stated that they had all the materials to complete the module, with one saying "posters still needed" and one saying that she received the materials through her facilitator. Forty-three (43/44) agreed that they were able to receive all necessary help from the facilitator. The one respondent who disagreed did not comment, but one other said positively: "facilitator helped a lot especially during peer review meeting."

Forty-three of the 44 also agreed that they will apply their new knowledge and skills, but unfortunately the one who disagreed did not comment as to why. However, three others made positive comments. Two said they had "already

started and it is working well" and one said she had "acquired skills to deal with adolescents."

Asked what they liked best about the module, 11 of the 44 noted the "upgraded knowledge of STI/ HIV/AIDS," eight (8/44) noted "knowledge about ARH," six (6/44) noted the "knowledge and skills in counseling," and five (5/44) said "everything about the module." Two people liked the "pre-test and paired learning meeting" and two liked the fact that the "module reinforces learning." One person liked the self-assessment, one liked the role-play, one liked the "facts for youth" and six others made no comment. One person used this space to note "interruptions when studying."

Asked to indicate problems, most people (40/44) had no problem or made no note of any. One respondent said she "could not complete the module due to sickness," one said she had "interruptions from clients," and one said her module was missing one page so she had to copy from her partner. One other person, rather than noting a problem, said that the "module was easy to understand." Asked to add other comments or observations, most (30/44) had none. Four people said, "SDL is educative so every midwife should be trained." Three stated that the "SDL has improved my knowledge" and one said "SDL has helped in IEC activities for adolescents." One person said: "need poster, and pamphlets for distribution after giving talk." One person noted that "there should be columns for sex, age and first ever use on family planning daily log and monthly return form." One person said, "paired learners should work together." One person said that the "whole program is interesting but it is time-consuming" and another suggested that "because of work load in maternity homes, six weeks should be used in completing a module." Looking to the future, one person commented: "we should visit training partners once in two months so we don't forget."

Learner Accomplishment Forms

Description of the form

The "Learner Accomplishment Form" was to be completed at the end of each month by the learner and submitted to the facilitator at the time of the peer review meeting. These forms were then forwarded to the Coordinator, who reviewed the contents to identify problems needing action. This form was completed anonymously. Its purpose was both to remind the learner to complete the required SDL tasks and to help the facilitators and coordinators know of any problems the learners were facing.

The form consisted of 12 statements against which the learner could tick "yes" or "no." After each statement, there was also a column for any comments the learner may have had.

Number of forms collected

There are four sets of learner accomplishment forms described in this appendix. One set of forms corresponds to Module 2, another set to Modules 3 and 4, a third group to Module 5 and a final set of forms for Module 6. This is because Modules 3 and 4 were treated together during the implementation of the SDL, causing most of the learners to complete only one learner accomplishment form for these two modules. Others completed one form for each of Modules 3 and 4, however these were in a minority and were equally divided across regions. Therefore, for purposes of this summary, the learner accomplishment forms are described in four groups, with Modules 3 and 4 considered together as one.

Table 24: Number of learner forms by module

Module	Number of Forms Received
Module 2	50
Modules 3 and 4	90
Module 5	46
Module 6	33
Total	219

Table 25: Percent of respondents who answered "Yes" to the question by module

Question	Module 2 (N=50) %	Modules 3 and 4 (N=90) %	Module 5 (N=46) %	Module 6 (N=33) %	Total (N=219) %
1. I have completed the module(s)	70.0	80.0	91.3	96.9	82.6
2. I have prepared questions for the paired learner meeting	84.0	60.0	71.7	51.5	66.7
3. I have attended the paired learning meeting for the previous module and have completed the related exercises	88.0	95.6	87.0	93.9	91.8
4 I have received my facilitator's field visit	68.0	88.9	93.5	96.9	86.3
5 I have discussed content and process with my facilitator	68.0	88.9	91.3	96.9	85.8
6. I have brought questions for today's peer review meeting	62.0	46.7	67.4	93.9	61.6
7. I had problems / difficulties with the module or the process	28.0	32.2	28.3	39.4	31.5
8. I have filled out the evaluation form for this module	82.0	93.3	95.7	87.9	90.4
9. I have filled in and used my calendar	72.0	90.0	93.5	84.8	85.8
10. I have filled in my Activity Plan	74.0	86.7	82.6	84.8	82.6
11 I benefited from the facilitator's field visit	70.0	87.7	91.3	96.9	85.8
12. I discussed my Activity Plan with my facilitator	64.0	83.3	91.3	96.9	82.6

Views of GRMA Facilitators and Implementers

In addition to the information gathered from the SDL learners, the evaluation gathered information from the main implementers of the SDL initiative: the GRMA Executive Director, the GRMA Coordinator of the SDL program, and the regional facilitators of the SDL program. (The in-depth interview guides appear in the appendices.) The findings gathered through this process are presented below, with unattributed quotations from the in-depth interviews.

In addition, for one part of this section (on the course design and materials development phase), information was also gathered by means of a questionnaire applied to key people in both GRMA and PRIME/Intrah involved in the SDL

course design and materials development. Information from those questionnaires is presented along with the relevant information from the in-depth interviews.

Planning and proposal development phase

The planning phase was the very first stage, during which the idea of organizing an SDL program on adolescent reproductive health was conceived and a project proposal was developed. The in-depth interviews made clear that the GRMA central office was pleased that it was actively involved in developing the initial idea with PRIME/Intrah/ROL. As one person said:

> *"It came about as a result of some studies done by GRMA/PRIME/FOCUS to assess needs of private members of GRMA.... [These along with regular support visits had] found that there were gaps in their counseling skills and CPI as well as in the facilities, such as privacy."*

After that research in 1997, discussions between GRMA and PRIME/Intrah/ROL about next steps included a proposal from PRIME/Intrah that a new training approach called SDL might be appropriate, and GRMA expressed the view that *"it would be good to pilot it."* The adolescent focus came about *"because we could just incorporate the special skills needed in addition for them. It was assumed that once the providers had acquired the skills, they could apply them to adults as well."* GRMA staff were enthusiastic in their comments about this phase, noting that the development of the initial ideas for the program were truly the result of a collaboration between GRMA and PRIME/Intrah.

However, GRMA was less involved in the development of the project proposal and initial action planning than they would have liked. The project plan was presented to them fully developed and with an action plan. As one person said: *"I was not too happy because PRIME/Intrah came with an action plan for implementation, and we have our projects and need to make our own work plans."* Noting that all of the project elements GRMA would have considered necessary were not included in that initial action plan, one person said about the project proposal and action plan development phase: *"I think the implementer has to be involved. The implementer definitely has to be involved."* In summary, although everyone is now very pleased with the results of the planning process which resulted in the SDL program, there is an indication that GRMA was less involved in the development of the project proposal and initial action planning than would have been ideal.

Course design and materials development phase

Information regarding the design and development phase was collected both through the in-depth interviews (described above) with two GRMA personnel and by means of a questionnaire completed by two GRMA staff and two PRIME/Intrah/PRIME staff-consultants that were part of the design and materials development phase. The questionnaire covered the design stage of the initiative,

meaning the conceptualization of this specific SDL course, and the development stage in which the modules were written and pre-tested.

The phase of designing the GRMA course and materials involved three GRMA people, two people from PRIME/Intrah/ROL and two specialists from PRIME/Intrah/CH as well one materials development consultant. The main sources used were the PRIME Source Book and the GRMA training curriculum, as well as other reproductive health books and the specialist knowledge of the participants. They worked first in the GRMA office in Accra, then, intensively over two weeks, in the PRIME/Intrah office in Lomé, followed by a pre-testing phase again in Accra. PRIME/Intrah in Chapel Hill finalized the documents in coordination with GRMA in Accra and PRIME/Intrah in Lomé.

Of the four people who completed the evaluation questionnaire about the design and materials development phase, two people - one from PRIME/Intrah and one from GRMA -responded specifically to the questions about the design phase (the others respondents stated that they were not involved). Strengths of the design phase noted by these two were:

That the SDL initiative originated out of an assessment performed of GRMA midwives and therefore responded to a perceived need of the association

That the design recognized the importance of a strong learner support system and the importance of teamwork and collaboration.

That a meeting of all stakeholders was held to brief people on how the activity fit with the GRMA's objectives.

The weakness of the design phase mentioned by both of these respondents was insufficient time to develop the project.

All four respondents answered questions regarding the development of the modules. Strengths of this phase mentioned were:

- That the developers of the modules were removed to work in a different place (PRIME/Intrah's Lomé office rather than GRMA's office in Accra) so that they were not disturbed by other work.
- That there were adequate reference materials readily available.
- That there was great team spirit and dedicated hard work (the GRMA participants praised the PRIME/Intrah input and the PRIME/Intrah people praised the midwives' input).
- That both intended learners (midwives) and specialists in instructional design were involved in the development phase.

Weaknesses of the development phase mentioned were:

- Not enough time (3 weeks) leaving a lot to be done afterwards;

- Electronic difficulties (different software versions, viruses, printer incompatibilities, e-mail breakdowns, telephone difficulties);
- Need for input from too many people; and
- Lack of clarity about the roles and responsibilities of PRIME/Intrah/Lomé staff versus Chapel Hill staff.

Asked if there were sufficient needs assessment data available at the time of the materials development, two replied "yes" (onr GRMA and one PRIME/Intrah) and two said "no" (one GRMA and one PRIME/Intrah). One commented: *"Though GRMA needs assessment data was available, the team felt is was rather too old...."* Another said: *"The information provided by GRMA's 1997 assessment was very helpful, but it was nearly two years old by the time we began developing the modules....More complete baseline data would have strengthened both the materials we developed and our ability to directly attribute improvements in performance [to] this intervention."*

All four agreed that the time available for materials development was not sufficient. One said: "Though team members worked around the clock, only two modules were ready by the time of the orientation. This led to a rush in making copies ready for the orientation. Thus the binding of these two modules was poor ... [and] the other Modules [numbers 3, 4, 5 and 6] also arrived quite late for copies to be made before peer review meetings."

Describing the pre-testing process, one of the interviewees said: "To pre-test we got six midwives from a non-intervention region. They were selected using the same criteria as the selection of the participant learners.... We asked them to read the modules...and comment on the difficulty level, language and cultural appropriateness, whether they thought a midwife could read it, and whether it was useful. All the modules 1-6 were tested in this way over three days."

Regarding the pre-testing process, the respondents noted as strengths:

- use of midwives from diverse backgrounds;
- adequate logistics; and
- hard work of the midwives and the consultant.

The main weakness of the pre-testing process noted was lack of time. (The pre-test methodology was focused more on clarity of language and presentation, whereas the real field test of the materials was actually this pilot phase under evaluation here.)

Overall the main facilitating factor mentioned by those completing the questionnaire was hard work by a dedicated team composed of both Ghanaian and international people. The main hindering factor was lack of time.

The in-depth interviews confirmed the findings from the questionnaire. As one person said:

"[T]he comments of the people who came from Chapel Hill reflected that they appreciated the inputs of the GRMA staff. [And] the people knew what they were about so the technical support was good." Both GRMA people interviewed also noted that it would have been nice to have more than three GRMA people involved in the materials development phase. But mostly, as one person said: "The main problem was time constraints. All other logistics were provided and taken care of. But there was not enough time."

In summary, the design and materials development process was smooth and well appreciated by all involved. Logistics were adequate for this phase according to the participants, however the overall time allocated was insufficient. The pre-testing process identified and improved some places in the text. However, as the earlier sections in this report indicate, some areas still remain unclear to learners and will need revising. The finalization of the module's content in Chapel Hill meant that Modules 3, 4, 5 and 6 arrived late in Ghana (after the orientation) and could not be reviewed and revised in country before dissemination (another indication of the shortness of time available).

Orientation

The orientation to the course lasted one week, with the first two days dedicated to facilitators and the remaining days for learners and facilitators. Three main concerns were raised about the orientation during the in-depth interviews, all linked to the fact that the available time for getting this pilot phase underway was very short. First, the facilitators felt they did not have enough time in their two days to fully understand their role and responsibilities as well as the course content and the SDL process. As one person said: *"I think they should have given us some two more days to go into detail."* Learners also felt that the time allocated for their orientation was insufficient.

Secondly, the fact that only the first two modules were available at the time of the orientation of the facilitators meant that they were not able to see the course as a whole before beginning. One person said: *"if we had had time to go through all the modules, it would have been better."* Another person commented that *"if the modules were sent to us prior to the orientation for us to look through, then it might have helped us."* The fact that the facilitators did not review the entire course together before the start meant that there were some questions having to do with the content raised by learners later on to which the facilitators were unsure how to respond. Later in the project, during the implementation, the facilitators each reviewed the additional modules alone and when questions arose, they relied on communication with the SDL Coordinator to try to resolve them. They appreciated this assistance, noting *"we had support from the Coordinator,"* but felt it would be faster and more efficient if they had resolved any questions all together before the start. Asked how the orientation might be improved, one person said: *"We could have gone through the modules one by one and discussed some issues that would come up [later]."* At the end of the in-depth group interview, when asked if they had any recommendations for improving the SDL program, the first recommendation given by the facilitators was: *"Next time sit down with the facilitators first and go through all the modules and agree."*

The third issue raised about the orientation was the size of the group of learners. One facilitator noted: "for learners, the group was too large. With 20 from each of the three regions, they were 60 so it was too large. So in the future, if it could be done for smaller groups it would be helpful. Maybe by region." Another facilitator said that the learners found the orientation confusing, "so it means if there had been a smaller group orientation it would have been much better." Learners also raised this concern.

In summary, the consensus of respondents was that: 1) the orientation was too short, for both facilitators and for learners and 2) with all the learners and facilitators together the size of the group was too large. In addition, since all the modules were not ready at the time of the orientation, facilitators were only able to review the first two modules before beginning the program.

Learner support system

The concept of the learner support system, as compared to self-study alone or traditional training, was well appreciated by the implementers. One person was effusive: *"It is **wonderful**. Wonderful in the sense that the paired learning activities came on quite well. They share ideas...one can say "I am reading this and I don't understand it. What do you think?" And then they can discuss it at peer review meetings in a bigger group. People come with their own experiences, which enrich your own learning. This is the excellent part of this approach."*

The problems encountered in implementing the learner support system had to do with transportation and communication. As one person said: *"Main problems were transport and communication. Our transport networks are poor, you know. Ideally if a learner is having a problem she should be able to get in touch with a peer or her facilitator or even the coordinator to get help. But these things could not always happen."* The problems of communication and transport particularly complicated the arranging of paired learning meetings and the associated facilitator visits. One person said: *"Because it was a new thing for us, we did not anticipate the difficulty with learners traveling to meet up. So we let them pair up with whomever they felt comfortable. Instead we should have had them pair up with the nearest other midwife. It was hard for the midwives to get transport. It was an extra financial commitment for them. Some of them are in areas that are really inaccessible."* Another person also noted this conflict between pairs selected for reasons of friendship or familiarity and pairs selected for convenience of travel: *."..the learners choose those that they feel comfortable with so they really enjoy it. Sometimes too they like to pair with their friends, regardless of distance, so that was also a problem. I mean in my area of operation three people had to form a unit because one wanted to pair with her friend, therefore the distance between the remaining two was so great that we had to add one to another group so we had three in that group."*

Serious problems arose if a meeting time needed to be changed by one of the partners or by the facilitator. Many maternity homes did not have telephones or could only be reached intermittently via a nearby telephone. In addition to emergencies requiring someone to stay at site or illness preventing someone from traveling, roads made inaccessible by heavy rain could also suddenly make a planned trip impossible. Once a trip was canceled at the last minute, it was difficult to reschedule the visit: the lack of rapid communication methods meant that a new time could not be arranged. The person would instead have to go on a visit without pre-arranging the time, and might not find the midwife present, requiring another attempt. This was a problem both for the facilitators and for the paired learners. The facilitators found this problem of communication and transport to be obstacle that caused them the most difficulties. As one said: *"In my area, communication was a problem. So everything was arranged at the peer review meeting, time of meeting and so on, and if there was a change, communication was very difficult. And I remember one visit I was not able to go, so I decided to do it on a Sunday because*

on Sunday most people are at home...So communication was a problem, contacting the learners. ...When I went to one area, she had gone to her outreach and I had to follow up to the outreach. And in fact I started at dawn and I came back at dark. So if you are not able to arrange everything at the peer review meeting, it is a problem." Another facilitator summed up by saying: *"What hindered me most was the communication between myself and the learners....I always had to try and keep to the plan, otherwise I had a problem."*

Transportation problems also created difficulties for monthly peer review meetings, another key part of the learner support system. This meeting generally lasted about two hours and was scheduled to take place before the general monthly meeting held by GRMA in each region. In general, this was considered a very good idea. As one person put it: *"It was ideal otherwise the midwives will be going out from their clinics twice in a month, it would be difficult, so I think they sacrificed one day for the peer review as well as the general meeting."* For the midwives, there were two great advantages to scheduling the meetings like this: they are away for only one day and therefore miss fewer clients (and the associated income) and they only have to cover the costs of one trip rather than two. This system worked well in one region in which the regular monthly meeting is held in the afternoons, making it possible to hold the peer review meeting at noon. However, in the other two regions, the peer review meetings were scheduled early in the morning so it would finish before the late morning regular monthly meeting. In these regions, the meeting was never able to start on time. As one person said: *"The problem applies especially to those who lived in really difficult places, it was hard for them to come for meetings. Some would have to come the night before in order to be there. Those who tried to come the same morning would arrive very late."* The peer review meetings would therefore start very late, holding up the regularly scheduled GRMA regional meeting.

Modules' content and presentation

The implementers generally appreciated the presentation of the modules. The only concern about the physical documents was the bindings on Modules 1 and 2, which were not robust. Otherwise the general presentation of the modules was well received. As one person said: *In terms of the layout, I think they are quite fine. When you look at them, a midwife can just look at it quickly and read what she feels she doesn't know. For this kind of program, this kind of presentation is good: small chunks of information presenting a topic. So one can pick one and read it in a short time.* However, a few learners suggested that there be a summary of key points on each topic: ."*..being adult learners, I would like that at the end of each topic they should put a key there of important things to remember, because they forget easily when they read, but if at the end it said these are the key areas you should remember it would help.*" Some disagreed with this, saying it would be better to leave a blank page and have the midwives write their own summary of learning from the section. But some said the self-assessment approach, which involved working out key points, did not

always work. One person said: *"The self-assessment, invariably most of them copy out their answers from the back, instead of just doing it from their head."*

In terms of content, there were a few queries raised. Several people said they appreciated the very simple way the menstrual cycle was explained, but two people said they were not sure the explanation was accurate. Several people queried the recommendation given in one module for vaginal administration of emergency contraceptive pills in case of nausea and vomiting when given orally, saying they thought absorption would be poor making the drug ineffective. One person said there should be more in the modules on progestin-only contraception and adolescents. In addition, text from one of the modules mentioned a telephone hotline that clients could call -- clearly a bit of text from a US or European source and entirely inappropriate to the context.

Most reference materials were "*very useful*," according to several respondents. A suggestion was made that videos for adolescents would be useful, since several midwives have now set up adolescent clubs. Also, several respondents expressed that they would have liked to have flyers to give to adolescent clients. However, in terms of further reference material for the learners, or changes to the content of the ones they received, no comments were made. One person did note that posters and reference sheets are more useful when they have been laminated in plastic. GRMA did so for some of the posters received as part of SDL.

Implementing and monitoring process

In general, respondents reported that the implementation went well. Learners and facilitators felt that they received adequate support from the coordinator and the GRMA office and they were very appreciative of that. The responsibilities of the coordinator role involved: seeing to logistics, communicating with stakeholders, collecting reports, managing funds, coordinating ongoing monitoring and alerting GRMA and PRIME/Intrah to any problems. In addition, the coordinator ended up serving as a technical point person. The coordinator's job was intended to be half time, but ended up being full time.

Two problems with the coordination process were mentioned. One was transport. It was not always possible for the office to allocate a vehicle to the SDL project if other activities were underway. The facilitators in the regions and the main office felt that four wheel drive vehicles allocated to the project would have helped the project, but everyone acknowledged that this might have been too expensive. One person made the practical suggestion that if the active phase of SDL had been implemented during the dry season, there would be fewer problems with transport.

The second implementation problem mentioned had to do with coordination between GRMA and PRIME/Intrah. The reporting requirements, in particular the financial reporting requirements, were not always clearly explained and were considered to be unnecessarily strict. The suggestion was made that there should be

a formal training session of key project staff on these matters and that financial reporting to ROL would be easier if the required processes were written down.

There was a strong feeling that GRMA's capacity to implement an SDL project had been developed, but that some assistance would continue to be needed. As one person said, *GRMA has definitely developed capacity, but not enough to do it completely on our own. We would need technical assistance, and financial. We don't have money.... We have the vehicles and computers and the manpower, but we don't have money*. Another person said, *It takes a lot of resources in the preparation phase. That is the thing about SDL, the major cost is in the preparation phase. So I don't know if we can develop something new all on our own. But once we have the materials, we may be able to get facilitators who would want to contribute their expenses or maybe GRMA could meet them half way. So that's what I have to say, the preparation phase would be hard for us, but maybe for the implementation phase the Association would meet it.*

Conclusions

Knowledge and Skills and Service Availability

The results of the observation of midwives during a simulated counseling session demonstrated that participation in the SDL/CPI initiative was associated with: overall better counseling performance, a greater likelihood of ensuring confidentiality and privacy for the client and a greater likelihood of addressing issues having to do with STI and HIV during a counseling session. In addition, participation in the initiative was also associated with a greater likelihood of both discussing sexuality generally and discussing the usefulness of contraception to adolescents during a counseling session.

While there remain several areas needing further emphasis to ensure that the learners acquire and apply new counseling skills, such as understanding the physical changes of adolescence and asking the client how she felt about the subjects under discussion, the overall results of the performance simulation component of this evaluation suggest that the SDL/CPI initiative was beneficial for both the participant midwives and their young clients.

Based on pre- and post-project self-assessments by the SDL learners of the volume and content of adolescent service provision in their clinics, it appears that RH services targeted to adolescents increased. Taken together with the evidence of improved counseling skills, it can be asserted that the quality and availability of ARH services improved among midwives who participated in the SDL/CPI initiative.

Finally, while the findings regarding knowledge were less conclusive than the findings regarding counseling practice and range of services offered, midwives who participated in the SDL initiative exhibited a better understanding of national policies regarding certain eligibility criteria after the training than they did before the training. In particular, trained midwives demonstrated an improved understanding that national policies do not allow a woman to be refused family planning services because she is unmarried or has not obtained the consent of her parents or her husband. In addition, learner midwives possessed a wider understanding of these eligibility criteria policies than did the control group of non-participants. However, insufficient numbers of midwives provided the correct response for many other knowledge areas and eligibility criteria. These included whether menses must be present to prescribe certain methods and for which methods examinations or tests are necessary.

Client Perceptions

There was little difference in the perceptions of the midwives and their service provision by adolescent clients of participants and non-participants in the SDL initiative. The one exception was perceptions of privacy: the clients of the SDL

participants were significantly more likely to say that the amount of privacy was adequate. Improving privacy for adolescent clients was a key element of the SDL course and participants reported making special efforts including changes in the layout of their clinics to improve privacy, as well as taking care to make sure counseling sessions are not overhead, in accordance with the knowledge gained from the SDL course.

Learner Perceptions

For the most part, the SDL participants provided positive feedback to the SDL initiative. The majority of learners felt that all aspects of the learner support system were helpful. Most of the learners received all of the reference materials and job aids although 20% reported not using them. The activity schedule and plans presented problems for many of the midwives and time constraints of various kinds were the most prevalent barrier to the implementation of SDL activities. Most importantly, despite the variety of challenges and improvements that were mentioned by the SDL participants, all of the respondents would recommend the continued and expanded usage of the SDL approach.

GRMA Facilitators' and Implementers' Perceptions

While the number of people interviewed for this assessment was very small, their feedback provided a number of useful suggestions for improvement. Time constraints were mentioned as the major difficulty encountered during most phases of the project. In addition, transportation and communication difficulties were encountered sometimes during learner support activities. The learner support approach utilized by the intervention was considered to be very positive and effective and the content of the modules was seen as appropriate. While it was felt that GRMA would continue to need some support to continue implementation of the SDL approach, respondents stated that GRMA's capacity was improved and that future support required would be less intensive.